

# **The Childbirth Experiences of Adolescent Mothers in the Western Cape**

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*“Be the change that you wish to see in the world” – Mahatma Gandhi*

## ABSTRACT

**Objective:** The objective of this study was to explore the lived childbirth experiences of middle adolescent mothers between 14 and 16 years of age.

**Methodology:** A qualitative design was followed, using Husserl's phenomenological approach. Information was gathered by semi-structured conversations. Identified themes and sub-themes (Colaizzi's steps) were presented to participants for authentication during follow-up conversations.

**Study Setting:** Two hospitals in the Cape Town Metropolitan area, Western Cape, South Africa.

**Participants:** Six adolescent girls between the ages of 14 and 16 years of age who had normal vaginal births of healthy, term infants.

**Findings:** An over-arching theme of *preservation of personhood* was identified. Themes and sub-themes were derived according to three Husserlian phenomenological concepts. Within these concepts three essential themes emerged from the conversations: i) *essences*: physically underdeveloped and emotionally unprepared for childbirth, ii) *intentionality and consciousness*: an unsettled state of mind during childbirth, and iii) *life-world*: feeling physically and emotionally overwhelmed by the experience.

**Conclusion:** The participants highly valued the presence of a support person; they indicated that their mothers were their first choice. Friendly, helpful, respectful and non-judgmental care from nurses and midwives were associated with more positive birth experiences while humiliation, victimisation and rudeness were associated with negative birth experiences.

**Implications for adolescent-friendly practice:** A condensed form of antenatal education is needed together with adolescent-friendly health care services to ensure better preparedness and experiences. Shared-decision making regarding certain aspects of childbirth is necessary. Continuous labour support is an important coping strategy and pain management is vital. Additional training is needed to address midwives' attitudes. Quality assessment tools are needed to address the mistreatment of maternity patients in health care facilities.

# CONTENT

DECLARATION.....	I
ABSTRACT .....	III
DEFINITIONS .....	XIV
ACRONYMS .....	XVI
CHAPTER 1.....	1
INTRODUCTION.....	1
1.1 INTRODUCTION .....	1
1.2 BACKGROUND TO THE STUDY.....	2
1.3 CONTEXT OF THE STUDY.....	2
1.4 ADOLESCENT PREGNANCY GLOBALLY.....	3
1.4.1 The Extent of Adolescent Pregnancy .....	4
1.4.2 Adolescent Pregnancy as a Public Health Crisis .....	5
1.5 THE PREVALENCE OF ADOLESCENT PREGNANCY IN SOUTH AFRICA.....	6
1.6 THE REALITY OF ADOLESCENT PREGNANCY IN SOUTH AFRICA.....	8
1.7 PROBLEM STATEMENT .....	10
1.8 RESEARCH QUESTION.....	10
1.9 AIMS AND OBJECTIVES .....	10
1.10 CONCLUSION .....	11
CHAPTER 2.....	12
LITERATURE REVIEW .....	12

<b>2.1</b>	<b>INTRODUCTION.....</b>	<b>12</b>
<b>2.2</b>	<b>SEARCH STRATEGY.....</b>	<b>12</b>
<b>2.3</b>	<b>REVIEW OF THE LITERATURE.....</b>	<b>14</b>
2.3.1	Childbirth Experiences .....	14
2.3.2	Adolescent Childbearing .....	17
2.3.2.1	Middle adolescence.....	17
2.3.2.2	Consequences of adolescent childbearing .....	18
2.3.2.3	HIV and adolescent pregnancy in South Africa .....	22
2.3.3	Adolescent Childbirth Experiences .....	23
<b>2.4</b>	<b>CONCLUSION.....</b>	<b>28</b>
<b>CHAPTER 3.....</b>		<b>29</b>
<b>PHILOSOPHICAL UNDERPINNINGS OF THE STUDY .....</b>		<b>29</b>
<b>3.1</b>	<b>INTRODUCTION.....</b>	<b>29</b>
<b>3.2</b>	<b>UNDERSTANDING PHENOMENOLOGY.....</b>	<b>29</b>
<b>3.3</b>	<b>EDMUND HUSSERL.....</b>	<b>31</b>
3.3.1	The Phenomenology of Edmund Husserl .....	31
3.3.2	Husserlian Phenomenological Approach .....	33
3.3.3	Husserl and Bracketing.....	33
<b>3.4</b>	<b>MY PRE-UNDERSTANDINGS .....</b>	<b>35</b>
3.4.1	Ontological Pre-understandings.....	35
3.4.2	Epistemological Pre- understandings .....	36
3.4.3	Methodological Pre-understandings.....	37
<b>3.5</b>	<b>CONCLUSION .....</b>	<b>37</b>
<b>CHAPTER 4.....</b>		<b>39</b>
<b>RESEARCH DESIGN AND METHODS.....</b>		<b>39</b>

<b>4.1</b>	<b>INTRODUCTION.....</b>	<b>39</b>
<b>4.2</b>	<b>RESEARCH DESIGN.....</b>	<b>39</b>
<b>4.2.1</b>	<b>Qualitative Research .....</b>	<b>39</b>
<b>4.2.2</b>	<b>Phenomenological Approach.....</b>	<b>40</b>
<b>4.3</b>	<b>RESEARCH METHOD.....</b>	<b>41</b>
<b>4.3.1</b>	<b>Study Setting .....</b>	<b>41</b>
<b>4.3.2</b>	<b>Population and Participant Invitation.....</b>	<b>42</b>
4.3.2.1	Population .....	43
4.3.2.2	Inclusion Criteria.....	43
4.3.2.3	Exclusion criteria.....	44
4.3.2.4	Sample Size.....	44
4.3.2.5	Participant invitation .....	45
<b>4.3.3</b>	<b>Information Gathering.....</b>	<b>46</b>
4.3.3.1	Drawings .....	48
4.3.3.2	Conversational skills.....	48
4.3.3.3	Methodological pre-understandings .....	49
<b>4.3.4</b>	<b>Information Unravelling.....</b>	<b>50</b>
4.3.4.1	Audio-recorded conversations .....	50
4.3.4.2	Field notes.....	52
4.3.4.3	Reflective journal.....	52
4.3.4.4	Independent coder .....	53
<b>4.4</b>	<b>TRUSTWORTHINESS.....</b>	<b>53</b>
<b>4.4.1</b>	<b>Credibility .....</b>	<b>54</b>
<b>4.4.2</b>	<b>Transferability .....</b>	<b>55</b>
<b>4.4.3</b>	<b>Dependability .....</b>	<b>55</b>
<b>4.4.4</b>	<b>Confirmability .....</b>	<b>56</b>



<b>4.5</b>	<b>ETHICAL CONSIDERATIONS.....</b>	<b>57</b>
<b>4.5.1</b>	<b>Principle of Respect for Persons .....</b>	<b>57</b>
4.5.1.1	Confidentiality.....	58
4.5.1.2	Autonomy .....	58
<b>4.5.2</b>	<b>Principles of Non-maleficence and Beneficence .....</b>	<b>59</b>
<b>4.5.3</b>	<b>Risks and benefits to participants .....</b>	<b>60</b>
<b>4.5.4</b>	<b>Principle of Justice .....</b>	<b>60</b>
<b>4.6</b>	<b>CONCLUSION .....</b>	<b>61</b>
<b>CHAPTER 5.....</b>	<b>62</b>	
<b>DESCRIPTION OF THE THEMES .....</b>	<b>62</b>	
<b>5.1</b>	<b>INTRODUCTION .....</b>	<b>62</b>
<b>5.2</b>	<b>DESCRIPTION OF THE PARTICIPANTS .....</b>	<b>62</b>
<b>5.2.2</b>	<b>Introducing the Participants.....</b>	<b>63</b>
<b>5.3</b>	<b>PARTICIPANT-RESEARCHER RELATIONSHIP .....</b>	<b>67</b>
<b>5.4</b>	<b>INFORMATION UNRAVELLING .....</b>	<b>68</b>
<b>5.5</b>	<b>EXHAUSTIVE DESCRIPTION.....</b>	<b>69</b>
<b>5.5.1</b>	<b>Before Labour .....</b>	<b>70</b>
<b>5.5.2</b>	<b>During Labour.....</b>	<b>70</b>
<b>5.5.3</b>	<b>During the Birth .....</b>	<b>71</b>
<b>5.5.4</b>	<b>After the Birth .....</b>	<b>72</b>
<b>5.6</b>	<b>THEMES USING HUSSERLIAN FRAMEWORK .....</b>	<b>72</b>
<b>5.6.1</b>	<b>Essences.....</b>	<b>72</b>
<b>5.6.2</b>	<b>Intentionality and Consciousness.....</b>	<b>73</b>
<b>5.6.3</b>	<b>Life-world.....</b>	<b>73</b>
<b>5.7</b>	<b>OVERARCHING THEME - PRESERVATION OF PERSONHOOD ...</b>	<b>76</b>

<b>5.8</b>	<b>EXPANSION OF THEMES AND SUB-THEMES .....</b>	<b>77</b>
<b>5.8.1</b>	<b>Essential Theme One: Unpreparedness .....</b>	<b>79</b>
5.8.1.1	Ignorance .....	80
5.8.1.2	Physically and emotionally unprepared .....	81
<b>5.8.2</b>	<b>Essential Theme Two: Unsettled.....</b>	<b>83</b>
5.8.2.1	Fearful .....	83
5.8.2.1.1	Fear of being alone .....	83
5.8.2.1.2	Fear about baby's well-being .....	84
5.8.2.1.3	Fear of mistreatment by the nursing staff .....	86
5.8.2.2	Submissive.....	87
5.8.2.3	Needs expressed by the participants to cope with their unsettledness...	89
5.8.2.3.1	Wants her mother with her during labour and birth .....	89
5.8.2.3.2	Wants ongoing encouragement and reassurance .....	92
<b>5.8.3</b>	<b>Essential Theme Three: Overwhelming Experience.....</b>	<b>93</b>
5.8.3.1	Intrapersonal experiences .....	93
5.8.3.1.1	Overwhelmed by pain .....	94
5.8.3.1.2	Overwhelmed by emotions.....	95
5.8.3.2	Interpersonal experiences.....	98
5.8.3.2.1	Dehumanised .....	98
5.8.3.2.1.1	Felt unimportant .....	99
5.8.3.2.1.2	Felt disrespected .....	101
5.8.3.2.1.3	Felt ignored.....	102
5.8.3.2.1.4	Felt victimised .....	104
5.8.3.2.2	Encouragement and kindness.....	105
<b>5.9</b>	<b>CONCLUSION .....</b>	<b>108</b>
<b>CHAPTER 6.....</b>	<b>110</b>	

<b>DISCUSSION .....</b>	<b>110</b>
<b>6.1 INTRODUCTION .....</b>	<b>110</b>
<b>6.2 PRESERVATION OF PERSONHOOD.....</b>	<b>110</b>
<b>6.2.1 Approaches in the Health Services in Support of Preservation of Personhood in Childbirth.....</b>	<b>111</b>
6.2.1.1 Consumer approach .....	111
6.2.1.2 Holistic approach .....	112
6.2.1.3 Health service approach.....	113
<b>6.2.2 The Midwifery Model of Care and Personhood.....</b>	<b>115</b>
<b>6.2.3 Personhood and its Relationship to Ubuntu .....</b>	<b>116</b>
<b>6.3 DISCUSSION OF LITERATURE ON THEMES AND SUB-THEMES.....</b>	<b>117</b>
<b>6.3.1 Unpreparedness.....</b>	<b>117</b>
6.3.1.1 Ignorance.....	118
6.3.1.2 Physically and emotionally unprepared.....	120
<b>6.3.2 Unsettled.....</b>	<b>126</b>
6.3.2.1 Fearful .....	126
6.3.2.1 Fear of being left alone .....	127
6.3.2.1.2 Fear of the baby's well-being .....	129
6.3.2.1.3 Fearful because of a lack of communication.....	130
6.3.2.1.4 Fear of mistreatment by the nursing staff.....	132
6.3.2.2 Submissive.....	135
6.3.2.3 Needs expressed by the participants to cope with their unsettledness	136
6.3.2.3.1 Mother as birth companion during childbirth.....	136
6.3.2.3.2 Ongoing encouragement and reassurance.....	137
<b>6.3.3 Overwhelming Experience.....</b>	<b>139</b>

6.3.3.1	Intrapersonal experiences .....	139
6.3.3.1.1	Overwhelmed by pain.....	139
6.3.3.1.2	Overwhelmed by emotions.....	141
6.3.3.2	Interpersonal experiences .....	142
6.3.3.2.1	Dehumanised.....	142
6.3.3.2.1.1	Felt unimportant .....	143
6.3.3.2.1.2	Felt disrespected .....	147
6.3.3.2.1.3	Felt ignored .....	149
6.3.3.2.1.4	Felt victimised.....	150
6.3.3.2.2	Encouragement and kindness.....	153
<b>6.4</b>	<b>ADOLESCENT CHILDBIRTH VERSUS ADULT CHILDBIRTH .....</b>	<b>158</b>
<b>6.5</b>	<b>DEVELOPMENTAL TASKS OF ADOLESCENCE AND THE EFFECT OF PREGNANCY.....</b>	<b>160</b>
<b>6.6</b>	<b>STRENGTHS OF THE STUDY .....</b>	<b>163</b>
<b>6.7</b>	<b>LIMITATIONS OF THE STUDY.....</b>	<b>166</b>
<b>6.8</b>	<b>CONCLUSION.....</b>	<b>168</b>
	<b>CHAPTER 7.....</b>	<b>170</b>
	<b>CONCLUSION .....</b>	<b>170</b>
<b>7.1</b>	<b>INTRODUCTION .....</b>	<b>170</b>
<b>7.2</b>	<b>OVERVIEW OF THE METHODOLOGY .....</b>	<b>170</b>
<b>7.2.1</b>	<b>Problem Statement.....</b>	<b>170</b>
<b>7.2.2</b>	<b>Aim of this Study .....</b>	<b>171</b>
<b>7.2.3</b>	<b>Study Design .....</b>	<b>171</b>
<b>7.2.4</b>	<b>Study Setting and Sampling Methods .....</b>	<b>171</b>
<b>7.2.5</b>	<b>Participant Invitation .....</b>	<b>172</b>

7.2.6	Information Gathering.....	172
7.2.7	Information Unravelling.....	173
7.2.8	Rigour of the Study .....	173
7.3	SUMMARY OF THE THEMES.....	173
7.3.1	Essential Theme one: Unpreparedness .....	174
7.3.2	Essential Theme two: Unsettled .....	174
7.3.3	Essential Theme three: Overwhelming Experience.....	175
7.3.4	Developmental Tasks of Middle Adolescents .....	175
7.4	ADOLESCENT CHILDBIRTH VERSUS ADULT CHILDBIRTH .....	175
7.5	RECOMMENDATIONS FOR NURSES AND MIDWIVES CARING FOR ADOLESCENTS DURING CHILDBIRTH .....	176
7.5.1	Addressing Ignorance.....	176
7.5.2	Addressing Fear .....	177
7.5.3	Continuous Support during Labour .....	178
7.5.4	Submission versus Autonomy .....	180
7.5.5	Pain Relief.....	181
7.5.6	Additional Training for Midwives and Nurses.....	181
7.5.7	Monitoring the Quality of Care.....	181
7.5.8	Adolescent-oriented Care.....	182
7.6	RECOMMENDATIONS FOR FUTURE STUDIES ON ADOLESCENT AND CHILDBIRTH.....	183
7.7	CONCLUSION .....	185
	REFERENCES .....	187
Appendix A:	Approval from the Human Research Ethics Committee.....	215

<b>Appendix B:</b>	<b>Permission from the Western Cape Government and Tygerberg Hospital ..... 216</b>
<b>Appendix C:</b>	<b>Permission from Mowbray Maternity Hospital..... 217</b>
<b>Appendix D:</b>	<b>Consent Information for Parent/Legal Guardian ..... 218</b>
<b>Appendix E:</b>	<b>Assent Information for Adolescents ..... 221</b>
<b>Appendix F:</b>	<b>Protocol Amendment ..... 224</b>
<b>Appendix G:</b>	<b>Independent Coder's Themes and Sub-Themes ..... 225</b>

## TABLES AND FIGURES

<b>Table 1:</b> The Consequences Of Early Childbearing .....	21
<b>Table 2:</b> Associated Factors Contributing To Adults And Adolescents' Childbirth Experiences .....	25
<b>Table 3:</b> The Impact Of Pregnancy On The Developmental Tasks Of Middle Adolescents. ....	162
<b>Figure 1:</b> The Number of Adolescent Pregnancies in South Africa from 2009 to 2013.....	7
<b>Figure 2:</b> Themes Identified using the Husserlian Framework.....	75
<b>Figure 3:</b> Presentation Of Essential Themes and Sub-Themes .....	78
<b>Figure 4:</b> One Part of Farrah's Drawing – of Her Experience at the MOU...	87
<b>Figure 5:</b> Aquila's Drawing .....	96
<b>Figure 6:</b> Cindy's Drawing .....	108
<b>Figure 7:</b> Preservation of Personhood: Three Different Approaches Supporting Personhood in Childbirth .....	114
<b>Figure 8:</b> Unathi's Drawing .....	117

## DEFINITIONS

### **Afrikaans**

This is an official language spoken in South Africa derived from the Dutch spoken by settlers who arrived in the country during the 17<sup>th</sup> century and settled in the Cape, it is one of the three main languages spoken the Western Cape (Oxford University Press, 2015a).

### **Black people**

Referring to any human racial group having dark-coloured skin especially from African origin (Oxford University Press, 2015b).

### **Coloured people**

Referring to people in South Africa with mixed-race ancestry (mostly Black, Koi-San and European) and formerly recognised as an official race classification in the country (The South African Department of Labour, 2004).

### **Low-risk pregnancy**

The anticipation of a complication-free pregnancy and minimal risk.

### **Multipara**

A woman who has given birth to more than one child (Oxford University Press, 2015c; Cronjé, Cilliers & Pretorius, 2011).

### **Nullipara**

A woman that has never given birth before.

### **Postpartum**

The postpartum period refers to the six weeks' immediately after a woman has given birth (Cronjé, Cilliers & Pretorius, 2011).



**Primipara**

A woman who has given birth for the first time (Oxford University Press, 2015d).

**Shoulder dystocia**

It is an obstetric complication that occurs during the birth of the baby. The baby's head has been born but the shoulders are impacted behind the mother's pubic bone and cannot be delivered by means of usual methods. Active management is required to ensure a safe delivery of the baby (Cronjé, Cilliers & Pretorius, 2011).

**Xhosa people**

The Black people in South Africa are classified according to different ethnic groups in the country. The Xhosa people are the second-largest ethnic group in the country and are traditionally from the Eastern Cape Province (Oxford University Press, 2015e).

## **ACRONYMS**

**HREC** - Human Research Ethics Committee

**ICM** - International Confederation of Midwives

**MOU** - Midwife Obstetric Unit

**WHO** - World Health Organisation

**WRA** - White Ribbon Alliance

# CHAPTER 1

## INTRODUCTION

### **Jane's story<sup>1</sup> – Saturday 28 June 2014**

*The light in the room is dimmed. The machine next to the bed beeps softly as the fluid runs through the line and into the tiny hand covered with plaster and resting on the bed covers. Jane's other hand is tucked close to her body; her thumb is in her mouth and every now and then she soothingly sucks. A peaceful scene at 2 o'clock in the morning in a hospital.*

*Two hours ago, Jane gave birth to a baby boy.*

*Jane is 14 years old. She had gone into preterm labour at 31 weeks gestation and had multiple seizures both at home and at the clinic. Jane had only been diagnosed with eclampsia<sup>2</sup> prior to her going into labour, thus requiring transfer to tertiary care. Two hours ago, the scene in this same room was one of screaming and kicking. Jane's shriek of pain and fear echoed through the labour ward before concluding with the cry of a tiny 1 000 gram baby boy who lay on the edge of the bed. His 14-year old mother lay alone, curled up and crying inconsolably - the pulsating umbilical cord between them; evidence of her new motherhood.*

\*\*\*

### **1.1 INTRODUCTION**

Adolescent pregnancy and adolescent childbirth are not new concepts in the research field but there is still a dearth in research regarding adolescents'

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<sup>1</sup> This is based on a real life event but Jane is used as an alias.

<sup>2</sup> A condition in pregnancy characterised by convulsions associated with hypertension and proteinuria and can occur antenatally, during labour or postnatally (Cronjé, Cilliers & Pretorius, 2011).

experiences of childbirth (Low et al., 2003). The scene described above is but one day in the adolescents' lives, but it marks the transition from merely being an adolescent into becoming a mother with a tiny, helpless human being depending on her. This particular day of transition into motherhood is the focus of this study - the day she gives birth and becomes a mother.

This chapter describes the background and context of the study. It presents the global and local statistics on adolescent pregnancy, since it is considered by many a public health crisis. The problem statement, research question and purpose of the study are summarised at the end of the chapter.

## **1.2 BACKGROUND TO THE STUDY**

Jane's narrative is a common one illustrating the type of labour that adolescent mothers may experience. This unique population of children giving birth to children has received little attention in the context of their lived experiences of giving birth.

My interest in adolescents' lived experiences of giving birth began when I was a student nurse in 2009. Later on in my career, working as a midwife in public (government) maternity hospitals in Johannesburg and Cape Town, I became more aware of my fellow midwife colleagues' judgmental attitudes and verbal abuse directed at adolescent mothers. This prompted me to study the phenomenon of adolescents' lived experiences of childbirth in the public sector.

## **1.3 CONTEXT OF THE STUDY**

The study was conducted in the public health sector in the Cape Town Metropolitan Area in the Western Cape province of South Africa. The study context involved two public sector referral hospitals. Referral hospitals are

secondary or tertiary institutions to which patients are referred from lower-level care facilities when they need more specialised care (Peninsula Maternal and Neonatal Service, 2010). Guidelines for maternity care list 16 years of age and younger as a risk factor for pregnant women (Department of Health, 2007). Consequently a hospital birth is required despite the fact that the adolescent may have an otherwise low-risk pregnancy.

In secondary and tertiary public hospitals, it is primarily midwives who care for maternity patients – including adolescents – during childbirth. The doctors are responsible for the medical and surgical management of high-risk patients as well as the management of complications, while midwives provide emotional, physical and psychological care during labour and assist the women during the birth process. Midwives are trained to manage certain obstetric emergencies; therefore the majority of patients in public hospitals are assisted by midwives and auxiliary nurses during vaginal deliveries.

Pregnant adolescents are admitted to the same antenatal wards and labour wards as pregnant adults and are cared for by the same midwives and nursing auxiliaries on a shift. During the postpartum period, mothers and babies are admitted to postnatal wards run mainly by midwives together with auxiliary nurses.

#### **1.4 ADOLESCENT PREGNANCY GLOBALLY**

Adolescent pregnancy has been a concern worldwide for many years. The extent of adolescent pregnancy globally and the standpoint of adolescent pregnancy as a public health crisis are presented in the following sections.

### **1.4.1 The Extent of Adolescent Pregnancy**

The focus of this study was on middle adolescent girls between 14 and 16 years, therefore the statistics presented in this section are age-specific where information was available.

The World Health Organisation (WHO) reports that around 16 million girls between the ages of 15 and 19 years, and about one million girls below the age of 15 years, give birth annually (World Health Organisation [WHO], 2014a). The majority of these girls are from developing countries and although adolescent pregnancy worldwide has declined since 1990, the poorest improvement in the prevention of adolescent pregnancies was in sub-Saharan Africa (United Nations, 2015a). According to the Millennium Development Goals 2015 report, adolescent pregnancies in these countries remain high among 15 to 19 year olds with an average of 116 births for every 1 000 girls compared to the world average of 51 births per 1 000 girls (United Nations, 2015a). The most recent available adolescent pregnancy statistics from South Africa indicate an average of 47 births for every 1 000 girls during 2014, while the world average was at 45 births per 1 000 girls (World Bank Group, 2014).

A report from the United Nations on age-specific fertility rates from 2010 to 2015 indicated pregnancies in South Africa among 15 to 19 year olds as an average of 50.9 births per 1 000 girls (United Nations, 2015b). To put this into context, the average fertility rate in South Africa of women between 20 and 24 years old was 129 births per 1 000 women and between 25 and 29 years old 133.1 births per 1 000 women (United Nations, 2015b). When all the fertility rates of the women between 20 and 49 years were grouped together, the average fertility rate of adult women in South Africa was 71.7 per 1 000 births (United Nations, 2015b). These statistics highlight the high adolescent

fertility rate in South Africa as more than two thirds of the total adult fertility rate.

Adolescent pregnancy is a global concern because of the associated health risks and socio-economic consequences. Even though there has been a slight decrease in the prevalence of adolescent pregnancy worldwide, complications during pregnancy and childbirth still endanger the lives of adolescent girls (WHO, 2014a). The second highest cause of deaths among girls between the ages of 15 and 19 years (following road-traffic injury) is pregnancy and ensuing birth complications such as unsafe abortions and severe blood loss during childbirth (WHO, 2014a). Ninety five percent (95%) of these births happen in developing countries among low- to middle-income households (WHO, 2014a).

#### **1.4.2 Adolescent Pregnancy as a Public Health Crisis**

A number of studies that discussed the prevalence and effects of this matter debated the standpoint of adolescent pregnancy as a public health crisis (Torres, Lau & Flores, 2015; Koffman, 2012; Jewkes, Morrell & Christofides, 2009; Bonell, 2004; Geronimus, 2004). Older studies that were found in the literature oppose the idea of adolescent pregnancy as a public health crisis. Lawlor and Shaw (2002) asked if adolescent pregnancy is a public health crisis or merely a reflection of the current economically, culturally and socially accepted norms. Rich-Edwards (2002) and Scally (2002) critiqued this standpoint by maintaining that the reality of many adolescent mothers in the United States of America (USA) is that they already face limited opportunities and few promises of improved social circumstances pre-pregnancy. However, in order to afford those adolescents who want to, ample opportunities and tools to escape the cycle of poverty and ill-health, adolescent pregnancy should be regarded as a public health crisis (Rich-

Edwards, 2002). Hoffman (1998) argued that research no longer supports the perspective that adolescent pregnancy is a disastrous event; however, recent literature is in agreement that adolescent pregnancy indeed poses a problem (Torres, Lau & Flores, 2015; Koffman, 2012; Jewkes, Morrell & Christofides, 2009; Bonell, 2004).

## **1.5 THE PREVALENCE OF ADOLESCENT PREGNANCY IN SOUTH AFRICA**

Multiple programmes and projects have been put into action in South Africa with the aim of decreasing the adolescent fertility rate (Murphy, 2014; South African Medical Association, 2011; Clayden, 2010). In 2009, the Department of Education released a report that was based on studies done from 2000 to 2008, showing a 2% incidence of pregnancy among 15 year olds and a 30.2% incidence among 19 year olds (Department of Education, 2013a; Panday, Makiwane, Ranchod et al., 2009). More recently, birth occurrences in South Africa among adolescent mothers aged 15 to 19 were recorded as 112 605 during 2012, of which 9 875 (8.7%) births were recorded in the Western Cape (Statistics South Africa, 2013a). This number was the fourth lowest percentage in South Africa, with KwaZulu-Natal being the province with the highest percentage of adolescent pregnancies at 26 672 (23.7%) during 2012. The number of births among mothers younger than 15 years of age was not specified, although 137 births had been recorded as unspecified or outside the 15 to 54 age range in the Western Cape (Statistics South Africa, 2013a).

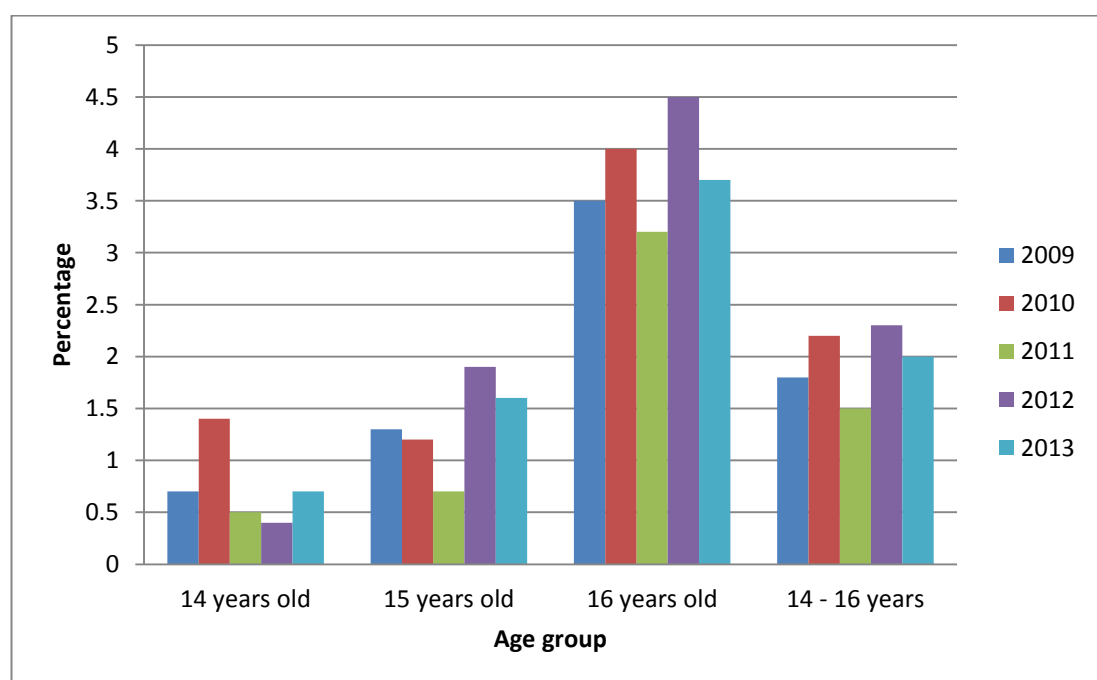
The general household survey from 2009 to 2011 reported a 4.5% prevalence of pregnancies among adolescents between 13 and 19 years (Statistics South Africa, 2014). During the triennium period from 2010 to 2012, adolescent pregnancies increased to 4.9% among all 13 to 19-year olds (Statistics South Africa, 2014). The latest general household reported that 5.4% of all girls in the age group 14 to 19 years were pregnant during 2013, while no



pregnancies were reported for 13-year olds (Statistics South Africa, 2012). This increase in the prevalence of adolescent pregnancy remains a national concern and often attracts media attention (Murphy, 2014; Skosana, 2014; Malan & Green, 2013; Rademeyer, 2013; Morrell, Bhana & Shefer, 2012; Veriava, 2012; IRIN News, 2007). The prevalence of adolescent pregnancies among the age groups relevant to this study, as reported by the general household surveys is presented in figure 1.

As can be seen in the figure, the prevalence of pregnancy has a marked increase at 16 years of age (Statistics South Africa, 2014; Statistics South Africa, 2013b; Statistics South Africa, 2012).

**Figure 1: The number of adolescent pregnancies in South Africa from 2009 to 2013**



Adapted from Statistics South Africa (2014); Statistics South Africa (2013b); Statistics South Africa (2012).

## **1.6 THE REALITY OF ADOLESCENT PREGNANCY IN SOUTH AFRICA**

Pregnancy among young adolescents is not an unusual sight in South African communities. During recent years it has become commonplace for a young girl to fall pregnant and for a 25 year old woman to have her second or third child while raising her children as a single mother. In my practice in the public sector I have often seen girls younger than 18 years being admitted to hospital for their second, often unplanned, pregnancy.

Adolescent pregnancy in South Africa is, however, influenced and affected by more than just lack of planning. It is driven by inequalities between the sexes, attitudes towards the supposed correct sexual behaviour for girls and boys, poverty, poor contraceptive use or access to these services, health professionals' judgmental attitudes, a lack of sex education and gender-based violence (Williams & Nair, 2013; Jewkes, Morrell & Christofides, 2009; Panday et al., 2009; Mfono, 1998).

Since adolescent mothers in South Africa are still stigmatised in their communities, they suffer from feeling guilt and shame (Mkhwanazi, 2006). Communities tend to focus only on the pregnant girl and to judge her, forgetting that there is also a father involved (Skosana, 2014). However, the father is often overlooked since he does not have an obvious identification as a father-to-be (Skosana, 2014).

Recent studies in South Africa have shown that among school pupils and some teachers, the focus is still mainly on the pregnant girl, blaming her for the pregnancy, while the boy's reputation is not tarnished (Sathiparsad, 2010; Bhana, 2010). Research indicates that gender-based inequalities are still major contributors to the adolescent pregnancy stigma (Sathiparsad, 2010). Young boys in schools believe it is their place and right to humiliate the pregnant

girls in their school (Sathiparsad, 2010). The boys remarked that they treat the girls badly in order to show them that what they have done (falling pregnant) was wrong, while exempting themselves from any responsibility (Sathiparsad, 2010).

In an attempt to delay early parenthood among male and female adolescents, campaigns and teenage pregnancy prevention programmes have been launched in South Africa (Taylor, Jinabhai, Dlamini et al., 2014; Department of Education, 2013b; SAMA, 2011). The Gauteng (province) Education Department aims to reduce the number of young women facing early parenthood and to educate them to wait until they have completed their education and are in a secure financial position, which better prepare them to become parents (Department of Education, 2013b).

A girl without an education does not have many options in today's life. Since a poor education excludes her from the labour market, she has to be satisfied with any kind of job that presents itself (Veriava, 2012). Additionally, due to an ensuing lack of finances, girls are more likely to enter into early marriages (Veriava, 2012). In contrast, a woman who completed her education, and possibly further education, can enter the labour market, affording her a much better opportunity to care for her children and to encourage them towards secondary and tertiary education (Veriava, 2012).

Reflecting on her experience of becoming a mother at 15, a South African woman recounted her experience and the biggest challenges she faced as a pregnant adolescent. She mentioned the fear of telling her parents, the patronising attitudes of nursing staff at the clinic, the judgmental attitudes of friends and teachers, trying to study with a new-born baby and the very unstable relationship with her baby's father (Engelbrecht, 2007).

## **1.7 PROBLEM STATEMENT**

In my experience of working as a registered midwife, I observed that few of the adolescent mothers had the support of the baby's father; in many instances the father was not involved with the expectant adolescent any longer. Most of the adolescent girls had their own mothers as birth companions, while others were alone. I also noticed indifference among adolescents towards important decisions, for example breastfeeding or formula feeding. Very few seemed to be autonomous regarding decisions concerning labour and/or the postpartum period. It seemed to me that adolescents were more fearful of labour and birth than older patients. I experienced the adolescent mothers to be a bigger challenge in terms of cooperation, understanding and support needed to ensure positive maternal and fetal outcomes. It appeared as if the adolescent mothers required more support and encouragement from the midwives than the older mothers did.

## **1.8 RESEARCH QUESTION**

How do middle adolescent mothers in the Western Cape experience childbirth?

## **1.9 AIMS AND OBJECTIVES**

The aim of the study was to explore the lived childbirth experiences of mothers of middle adolescent age who are currently living in the Western Cape. The objectives of the study were to determine the needs of adolescent mothers during childbirth and to make recommendations towards the future care of these mothers.

## **1.10 CONCLUSION**

Adolescent pregnancy is not an issue that will disappear overnight; on the contrary, it might never disappear completely. Where other studies focused on adolescent pregnancy or adolescent parenthood, this study focused on the experience which linked the two. Many aspects of adolescent pregnancy are still unexplored (Low et al., 2003). This study however, will start exploring at the beginning - the day on which they give birth.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

Edmund Husserl's phenomenological approach was followed in conducting this research. This approach requires the researcher to set aside her own thoughts and ideas about the phenomenon under study and to learn as much as possible about the phenomenon during fieldwork and information unravelling (McConnell-Henry, Chapman & Francis, 2009). Therefore only a short literature review is presented in this chapter. The available literature that was reviewed focuses on the concept of middle adolescence, middle adolescent childbirth experiences and the known health and socio-economic consequences of adolescent childbearing globally as well as in South Africa. An in-depth interaction with the literature is presented in chapter 6, in which the themes and sub-themes are discussed. The search strategy used for the in-depth literature review is described in section 2.2.

#### **2.2 SEARCH STRATEGY**

The search strategy used to source suitable literature included the following.

- Databases  
By platforms such as EbscoHost, consisting of various databases including PubMed, CINAHL, MEDLINE, Africa-wide, Health Source.  
  
Digital libraries such as JStore, Elsevier, Wiley Online Library and Sage Journals.
- Keywords during initial search strategy

Middle adolescence; teenage/adolescent pregnancy; teenage/adolescent childbirth experiences; childbirth experiences; labour and birth.

- Keywords in conducting the in-depth literature review were related to the themes and sub-themes

Teenage/adolescent labour support; teenage/adolescent childbirth abuse; teenage/adolescent victimisation; childbirth preparation, childbirth education, teenage/adolescent childbirth nursing care; childbirth/labour pain assessment. Where 'childbirth experience' yielded literature on adult women's experiences, this literature was included when comparisons to the experience of adolescents were presented.

- Search criteria

Date range: Literature from the last 10 years was included, viz. 2005 to 2015; earlier studies were, however, included if the content was relevant to my research, since not many studies were done on adolescent childbirth experiences.

Types of articles: All articles searched for were peer reviewed. Full articles and some abstracts were included. All research designs were included for example qualitative, quantitative, ethnographic, meta-analysis and systematic reviews.

Languages: Articles and abstracts presented in English or Afrikaans.

- Exclusion criteria

Instrumental/assisted births, preterm births, still births and intrauterine deaths.

Articles on experiences of parenthood or motherhood.

## **2.3 REVIEW OF THE LITERATURE**

The overview is structured to address the broad concept of childbirth as an introduction to the literature, followed by certain aspects of childbirth that overlap with my research. These aspects are the concept of middle adolescence; the known health and socio-economic consequences of adolescent childbearing; and the prevalence of HIV in pregnant adolescents in South Africa. The literature is then narrowed down to studies directly related to adolescent childbirth experiences and that which is evident about this phenomenon in current research.

### **2.3.1 Childbirth Experiences**

Research on childbirth experiences is ongoing; however, there is still a lack of research on women's birth satisfaction and contributing factors to enhance birth satisfaction (Goodman, Mackey & Tavakoli, 2004). The aim of a few studies in particular was to determine certain factors that influence childbirth experiences more positively or negatively such as mothers' experiences of natural and surgical births respectively; adjusting to parenthood; and exploring certain fears related to childbirth (Lupton & Schmied, 2013; Cipolletta & Balasso, 2011; Sapountzi-Krepia et al., 2011; Sawyer et al., 2011); Rijnders et al., 2008; Zar, Wijma & Wijma, 2001). Lupton and Schmied (2013) reported the experience women had at the exact moment of giving birth as being greatly influenced by the mode of delivery. Women who had vaginal births experienced intense physical pain at the moment of birth while women who underwent caesarean sections felt alienated from their bodies (Lupton & Schmied, 2013). Cipoletta and Balasso (2011) identified autonomy during childbirth, having a birth companion and a mother, as well as a baby-friendly birth environment, as factors that influenced women's satisfaction of their birth experiences more positively (Cipoletta & Balasso, 2011). Rijnders et al.



(2008) found that women who reported negative feelings regarding their childbirth experiences three years postpartum, indicated assisted vaginal deliveries, unexpected caesarean sections, no home births, being referred during labour, non-satisfaction with pain relief and unsympathetic health professionals as contributing factors.

Childbirth is a subjective experience. The satisfaction that a woman feels with regard to this life-changing experience differs from woman to woman. It depends on a variety of factors including her psychological preparedness, social circumstances, cultural influences and support structures during her pregnancy and during childbirth (Sawyer et al., 2011; Bryanton et al., 2007; Liamputtong, 2005; Chalmers & Quliyeva, 2004). In research on positive birth perceptions, women mentioned that to be able to actively participate in the birth, to be able to bond with their infants immediately after birth, to have their partners as birth companions and to be able to participate in decision-making as strong predictors of more positive birth experiences (Bryanton et al., 2007).

Sawyer et al. (2011) studied women's experiences of pregnancy through to the postpartum period and factors contributing to psychological distress. Participants from Sawyer's study indicated certain stressors that caused them psychological distress such as having a baby out of wedlock, the financial obligation associated with children, minimal partner support, having a baby girl (associated with negative cultural beliefs) and fear of the possible complications associated with childbirth (Sawyer et al., 2011). Liamputtong (2005) reported how financial and social circumstances and education play a role in women's childbirth experiences: middle class women generally have the financial resources to afford better or private care and are more outspoken about having their choices and opinions acknowledged during childbirth than lower class women (Liamputtong, 2005).

Research on childbirth experiences is not limited to childbirth, but extends to the long-term effects of women's positive or negative birth experiences on their psychological well-being. These effects include improved postnatal functioning and reduced stress levels after positive birth experiences, as well as perceived high-quality nursing care (Michels, Kruske & Thompson, 2013; Gürber et al., 2012). Michels, Kruske and Thompson (2013) explored the relationship between labour and birth satisfaction and the postpartum psychological functioning of new mothers. According to their findings, mothers who reported good birth experiences and felt cared for during childbirth experienced a much higher level of postpartum functioning than the mothers who reported less positive experiences (Michels, Kruske & Thompson, 2013). Gürber et al. (2012) have linked a higher satisfaction rate with childbirth to lower levels of postpartum depressive symptoms and acute stress reactions when tested three weeks postpartum. Caregivers' supportive behaviour during labour was indicated as an important predictor of women's subjective childbirth experiences and a high level of caretaker support was linked to lower distress symptoms (Gürber et al., 2012).

Childbirth has been described as a loss-of-self experience during which women might find it difficult to make sense of their bodies and its functions during childbirth (Lupton & Schmied, 2013). Women might need time to adjust to a kicking fetus inside their bodies suddenly changing into a real person - a crying baby outside their bodies. During childbirth women realise the power of their bodies and the changing of boundaries of their own self-esteem (Lupton & Schmied, 2013). This study was not age-specific but described a moment that all women have to go through when they give birth, regardless of their ages. Erikson (1959) stated that adolescents face an already challenging developmental phase where they go through bodily changes and try to establish their own identities. Therefore the process of childbirth creates an even more challenging time for the pregnant adolescent.

### **2.3.2 Adolescent Childbearing**

Adolescent childbearing as a middle adolescent and the consequences of adolescent childbearing is discussed in this section in terms of the following: health, education and socioeconomic consequences and the risk of infection with the Human Immunodeficiency Virus (HIV) among adolescent girls in South Africa.

#### **2.3.2.1 Middle adolescence**

This study focused on adolescents between 14 and 16 years old; an age group that is classified as middle adolescence based on Erikson's theoretical model of human development (Sadock & Sadock, 2007). Erikson's model focuses on human development and describes the eight stages of the life cycle. Adolescence is mentioned in the fifth stage: identity versus role confusion (Sadock & Sadock, 2007). Adolescence is described as 'a way of life between childhood and adulthood' (Erikson, 1968:128).

Erikson's theoretical model states that the question of identity becomes prominent at the onset of puberty and the extensive social and physiological changes (Erikson, 1968). Childhood roles and fantasies are no longer appropriate but the adolescent is not yet equipped to become an adult (Sadock & Sadock, 2007).

As soon as adolescents start experiencing role confusion, they tend to over-identify with leaders or heroes of popular groups in an attempt to find their own identity; instead they reach a point where they lose their identities entirely – referred to as identity diffusion (Erikson, 1959). Adolescents prefer to follow popular groups' behaviour because they can identify with someone else going through the same body changes and role confusion that they experience (Erikson, 1959). Adolescents thus get through this stage by

forming intimate groups with one another and often become intolerant and judgmental towards anyone they view different to themselves (Erikson, 1959).

#### 2.3.2.2 Consequences of adolescent childbearing

Erikson's identity diffusion can also be described as a 'crisis among crisis' when issues of sexuality and self-worth that were not resolved in childhood come to the fore, causing self-doubt and an identity crisis (Clarke-Stewart & Friedman, 1987:592). This identity crisis forms an intricate part of adolescence and, in the case of my study, extends to adolescent pregnancy and the crisis of being pregnant as an adolescent. Adolescence is a time during which young people have to deal with developing their own identity, sexual awareness and sexual relationships. To be faced suddenly with the responsibility of parenting is life-changing and adds a great deal of stress to their lives (Wahn, Nissen & Ahlberg, 2005). Wahn, Nissen and Ahlberg (2005) had conversations with pregnant adolescents from Sweden and explored their experiences of motherhood. The authors identified different reasons why adolescents become mothers. These reasons include negative social circumstances at home, a family pattern of adolescent pregnancies and no future opportunities to work towards (Wahn, Nissen & Ahlberg, 2005). Adolescents experienced the transition into motherhood as a way of becoming more responsible and deemed more mature by society but, in contrast, the adolescents also experienced condescending treatment and little support from society (Wahn, Nissen & Wahlberg).

Using an ethnographic methodology, Mkhwanazi (2010) undertook a study to explore teenage pregnancies in a post-apartheid South African township in the Western Cape. The girls were between the ages 16 and 25. During conversations with them, Mkhwanazi (2010) found that the adolescent

mothers' pregnancies were mostly unexpected and unplanned. However, abortion was never regarded as an option since most of the participants and their families believed that this was morally wrong (Mkhwanazi, 2010).

Apart from economic and social repercussions, childbirth among younger mothers is associated with many physical complications for example pregnancy-related hypertension, cephalo-pelvic disproportion (CPD)<sup>3</sup> and abruptio placentae<sup>4</sup> (Panday, Makiwane, Ranchod et al., 2009). A high incidence of maternal deaths<sup>5</sup> is associated with adolescent pregnancy; the WHO reported that during the 2000 – 2012 period, a total of 296 002 deaths due to maternal conditions were recorded, of which 53 were among five to 14 year old girls (type of maternal condition unspecified) and 150 983 were among 15 to 29-year olds (World Health Organisation, 2015a).

One of the objectives for improving maternal health (Millennium Development Goal 5<sup>6</sup>) was to reduce the number of adolescent pregnancies in developing countries by achieving universal access to reproductive health care (United Nations, 2013). According to the official report on the

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<sup>3</sup> Diagnosed only during labour, a condition where the fetus does not descend through the birth canal due to, for example, abnormal lie, being a large fetus (more than 4 kg) or certain pelvic conditions despite adequate uterine contractions, which requires a caesarean section (Cronj, Cilliers & Pretorius, 2011).

<sup>4</sup> An emergency during pregnancy or labour defined by a premature detachment of the placenta from the uterine wall, which can lead to an intra-uterine death of the fetus and severe blood loss, to death, for the mother if not medically managed (Cronjé, Cilliers & Pretorius, 2011).

<sup>5</sup> The death of a woman resulting from any health problem related to or aggravated by pregnancy, birth or postpartum period, including 42 days after the pregnancy has been terminated, regardless of the duration of the pregnancy, but excluding accidental or incidental causes of death (World Health Organisation, 2015b).

<sup>6</sup> The Millennium Development Goals were set for the time period 1990 to 2015, during which time my research was conducted. The reduction of adolescent pregnancies was part of the goal to improve maternal health (United Nations, 2013). A new set of goals were adopted for the 2016 to 2030 period called the Sustainable Development Goals; although reduction of adolescent pregnancies is no longer a target, the reduction of maternal mortality and universal access to family planning and reproductive care are set, among others, as new targets (United Nations, 2015a, United Nations, 2015c).

achievement of these goals, the contraceptive use among women between the ages of 15 and 49 increased to 64% in 2015, a 9% increase from 1990 to 2015 (United Nations, 2015a).

The World Health Organisation, in conjunction with international and local research studies, has voiced its concern over the years about the health outcomes for young mothers and the negative impact on the nutritional status of these babies (World Health Organisation, 2014b). Due to lower than average birth weights and poor socio-economic status such as poverty and limited access to education these babies do not always receive adequate nutrition to fulfil their health and developmental needs (WHO, 2014b; Panday et al., 2009.; LeGrand & Mbacké, 1993).

The Save the Children organisation stated that falling pregnant as a young adolescent puts the mother and her baby at a twofold higher risk of dying than adult mothers as a result of pregnancy or birth-related complications (Save the Children, 2004). Similarly, the babies of these young mothers face a higher risk of dying not only during pregnancy but also during childbirth, as well as before they reach the age of one year, they are at a 50% higher chance of dying than babies born to women in their twenties (Save the Children, 2004). An estimated one million babies born to adolescent mothers die each year due to pregnancy and childbirth complications (Save the Children, 2004). Mothers younger than 14 years are the most at risk. An adolescent's body is still developing; when it is not physically mature to deal with pregnancy and labour, obstructed labour often occurs, resulting in disabled babies as well as low birth babies being born prematurely (Save the Children, 2004).

A report on the State of the World's Mothers during 2013 focused on the survival of new-born babies on the first day of life. Enhancing girls' education and conducting more effective family planning, both measures to

prevent pregnancies when women are too young or too old, have been recommended as strategies to improve neonatal outcomes (Save the Children, 2013).

Panday et al. (2009) reported on adolescent pregnancy in South Africa and described the consequences - socially, economically, educational, health-wise - of early childbearing on adolescents. These results are presented in table. 1.

**Table 1: The Consequences of Early Childbearing**

<b>Health consequences</b>	<b>Economic consequences</b>
<ul style="list-style-type: none"> <li>• Elevated risks of maternal death</li> <li>• Elevated risk of obstetric complications</li> <li>• Low birth weight</li> <li>• High risk of infant mortality</li> </ul>	<ul style="list-style-type: none"> <li>• Lower family income</li> <li>• Increased dependency ratio</li> <li>• Exacerbated poverty</li> <li>• Children most likely to be poor</li> </ul>
<b>Educational consequences</b>	<b>Social consequences</b>
<ul style="list-style-type: none"> <li>• School drop-out</li> <li>• School absenteeism</li> <li>• Poor academic performance</li> <li>• Lower educational attainment</li> <li>• Poorer cognitive development of children</li> <li>• Poorer educational outcomes for children</li> </ul>	<ul style="list-style-type: none"> <li>• Stigma and discrimination</li> <li>• Less likely to be married</li> <li>• Most likely to suffer abuse</li> <li>• Less supportive and stimulating home environment for children</li> <li>• Increased behaviour problems among children</li> <li>• Higher rates of imprisonment among sons</li> <li>• Children more likely to give birth as teens</li> </ul>

Adapted from Breheny & Stephens, 2007; Hoffman, 2006; Kirby, 2007, as tabulated by Panday, Makiwane, Ranchod & Letsoalo, 2009:47; table 11.

Branson, Ardington and Leibbrandt (2015) conducted a study in Cape Town, with the aim to determine if childbearing in young mothers has adverse outcomes on the babies' health. The sample consisted of approximately 2 000 young Black<sup>7</sup> and Coloured<sup>8</sup> mothers, aged 14 to 22 years, over a period of seven years. These babies were more prone to being born with low birth weight, to have stunted growth and to be shorter than the average height for their age than babies of older mothers (Branson, Ardington & Leibbrandt, 2015). The authors concluded that early childbearing indeed adversely affects the outcome for both the baby and the mother. Educational programmes and information sharing that encourage adolescents to postpone their first pregnancy to at least until after 19 years of age were recommended.

#### 2.3.2.3 HIV and adolescent pregnancy in South Africa

Although the topic of this study focuses on adolescent mothers' physical and emotional experiences of childbirth, the concept of the Human Immunodeficiency Virus (HIV) has to be considered since it is a grave concern in South Africa and greatly affects young girls in this country. South Africa has the highest prevalence of HIV-infected people in the world, with 6.3 million known HIV cases in 2013, of which 3.5 million were women in their reproductive years (World Health Organisation, 2015c; World Health Organisation, 2015d).

The general household survey of 2013 showed that 5.4% of all girls between the ages of 14 and 19 were pregnant during that year (Statistics South Africa, 2014). Young women aged 15 to 24 years are at high risk of HIV infection due to numerous factors. These include having older sex partners (referred to as

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<sup>7</sup> See definitions

<sup>8</sup> See definitions



sugar daddies by the media), those who had multiple sex partners, young girls operating as transactional sex workers and also due to their vulnerability to gender-based violence (Malan & Green, 2013; Older men blamed for high HIV rates among schoolgirls, 2013; UNAIDS, 2013; Teen pregnancy figures drop, 2012; Panday et al., 2009). The prevalence of HIV in pregnant adolescent girls in South Africa between the ages of 15 and 19 years was reported as 18.8% during 2011, and decreased to 12.4% during 2012 (Department of Health, 2013a; Department of Health, 2012). The prevalence of HIV among the different population groups were not compared to the different age groups; however, the two population groups represented by my research showed a prevalence of 31% HIV-positive antenatal African (Black) women and 7.5% HIV-positive Coloured women during 2012 (Department of Health, 2013a).

Women - including sex workers - often do not use contraceptives, antenatal care or have themselves tested for HIV. Among adolescents, this is usually due to a lack of sex and contraceptive health education and negative perceptions regarding contraception - such as weight gain - or cultural influences regarding family planning - such as religious beliefs that contraceptive use is morally wrong (Mkhwanazi, 2006; Panday et al., 2009). Additionally, the fear of being stigmatised by others or being afraid of health professionals' attitudes - judging instead of educating them and providing them with contraceptives, may prevent adolescents from seeking health care (Williams & Nair, 2013; Mkhwanazi, 2006; Panday et al., 2009).

### **2.3.3 Adolescent Childbirth Experiences**

A woman approaches labour with certain expectations (Christiaens & Van de Velde, 2013). Since many births occur in hospitals, women might have certain expectations of hospitalisation during childbirth as well. Whether she has

preconceived ideas because of previous births, because of what friends told her, because of information she obtained from books or because of her cultural background, she has certain expectations with regard to her labour and giving birth. Anderson and McGuinness (2008) linked a positive birth experience to the mother's positive feelings towards her new baby and helping her to adapt to parenthood. Although many factors are influencing a woman's anticipation towards labour and birth, many factors also influence her actual experience of the event such as intrapartum nursing care, partner support, fear of childbirth and pain management (Anderson & McGuinness, 2008).

Limited research was found that focuses only on the adolescent and her experience of childbirth. Multiple studies explored the factors contributing to adolescents becoming pregnant. These studies mentioned differences in terms of the social acceptance of their pregnancies, different supportive needs, childbirth and psychological distress associated with the pregnancy (Mollborn & Jacobs, 2012; Mollborn & Morningstar, 2009; Wahn, Nissen & Ahlberg, 2005). Before childbirth, adolescent mothers face different challenges from adult mothers due to social norms they are believed to have violated by falling pregnant as an adolescent. After childbirth these challenges include managing various tasks simultaneously such as completing school, having to work for the first time, possibly moving out of their childhood homes, becoming financially independent and forming long-term relationships (Mollborn & Jacobs, 2012).

Low et al. (2003) reported that adolescents' perceptions differ from those of adults when it comes to childbirth experiences because of the following: i) adolescence is a period during which young people develop their identities and establish their own autonomy by testing different roles in an attempt to find the one that best fits them, and to figure out who they want to be; and ii)

experimentation is characteristic of this phase of development, but involves risks such as falling pregnant while not being prepared for it and having limited life experience to base her parenting on. This relates closely to Erikson's theory of development of adolescence and how adolescence is a period of identity diffusion with adolescents trying to establish their own identities in society and among their peers (Erikson, 1959). Low et al. (2003) compared the characteristics (shown in table 2) of adolescents and adults' positive birth experiences.

**Table 2: Associated Factors Contributing to Adults and Adolescents' Childbirth Experiences**

<b>Factors associated with positive birth experiences for adults - based on existing literature</b>	<b>Factors associated with adolescents' birth experiences - based on a study done by Low et al.</b>
'Attending antenatal education classes Confidence, sense of self-efficacy Supportive birth environment Participation in decision making Sense of control or being in control Decreased anxiety preceding birth Supportive health-care provider Realistic expectations prior to labour Quality pain management Presence of a spouse or support person Explanation of test and procedures Having a sense of mastery Having a vaginal birth Immediate contact with the infant Partnership with the health-care provider	Experience not dependent on classes Minimal planning or expression of efficacy Supportive environment with family/peers Assisted in decision making with education Dialogue regarding control was absent Anxiety regarding issues other than birth Active compassionate health-care provider Minimal planning prior to labour Supportive care to decrease pain Presence of supportive family and friends Explanation of and education about tests Sense of mastery dialogue absent Vaginal and caesarean births were positive Need education about initial baby contact Therapeutic mentorship role of health-care provider'

Adapted from Low et al. (2003:195)

The dynamics surrounding childbearing play a major role in adolescents' experiences of childbirth. In general, adult women experience childbirth as challenging, adolescents sometimes find it overwhelming, seeing that they are not physically fully developed or psychologically prepared (Sauls & Grassley, 2011).

A study conducted in Sweden that explored the experiences, expectations and outcomes of birth of 1 293 first-time mothers between the ages of 15 and 43, showed that women's expectations with regard to childbirth and their experiences thereof differ in accordance with their ages (Zasloff, Schytt & Waldermström, 2007). The authors found that the older women's difficult deliveries and dissatisfaction with birth could possibly be attributed to the biological differences between the age groups. The authors suggest that the lower maternal age groups were more likely influenced by their social context, as younger women may be more vulnerable because of emotional immaturity, a less significant educational background and/or a lack of life experience (Zasloff, Schytt & Waldermström, 2007).

Enderle et al. (2012) explored the qualitative factors of care that adolescents found helpful during childbirth. Care is described as the adolescents' understanding, communicating and actively participating in their births (Enderle et al., 2012). Care is further identified as addressing the adolescents' needs during childbirth and acknowledging that they find themselves in an unfamiliar environment, not being familiar with procedures. Establishing good communication channels and respecting autonomy are also mentioned as helpful factors during childbirth (Enderle et al., 2012).

Sauls & Grassley (2011:24) conducted a study during which they developed the Adolescent Support Model (ASM). The model assesses the intrapartum care and needs of adolescents. The Adolescent Support Model is based on the

following four assumptions: (i) 'childbirth is a pivotal event of powerful psychological importance in a young woman's life'. The childbirth experience, whether positive or negative, can have an impact on the psychological outcomes for both the mother and the baby. A positive childbirth experience can result in a positive attitude toward motherhood and positive feelings towards the infant; (ii) 'a positive childbirth experience can set the stage for a positive breastfeeding experience'; (iii) intrapartum nurses' professional support during labour can increase a mother's chances of having a positive childbirth' and breastfeeding experiences; (iv) adolescence is a transition stage between childhood and adulthood, and adolescents' unique developmental needs affect the way in which they experience childbirth (Sauls, 2011:24-25). Although the ASM was developed based on an already existing labour support model, it has not yet been tested on adolescents to determine the effectiveness of the supportive measures during childbirth.

During adolescence, parental influence on the adolescent is often of less importance than peer pressure and influence. Adolescents experience the need to fit in with their peers and might display unusual behaviour in an attempt to do so (Erikson, 1968). When this behaviour leads to pregnancy, the adolescent often finds it difficult to cope with labour and childbirth due to limited coping resources; resources that are only attained from life experience. Worry, fear of the future and fear of how they will cope with a new baby may contribute negatively to their experience of childbirth (Montgomery, 2003). According to Montgomery (2003), adolescents' physical needs during pregnancy are very similar to those of adult women; however, they present with different emotional needs. Since they have less life experience than adult women to apply as coping mechanisms, they experience pregnancy and childbirth as more challenging (Montgomery, 2003).

## **2.4 CONCLUSION**

A great need exists for research on adolescents and their childbirth experiences. The limited research available provides inadequate information about childbirth from adolescents' perspectives. In-depth research is needed to better understand the phenomenon of adolescent childbirth experiences.

## **CHAPTER 3**

### **PHILOSOPHICAL UNDERPINNINGS OF THE STUDY**

#### **3.1 INTRODUCTION**

Various phenomenologists followed and interpreted the discipline of phenomenology. This study was guided by the phenomenology as described by Edmund Husserl. This chapter aims to explore and describe the philosophical underpinnings that guided my study. A brief background of phenomenology is provided, followed by a description of the phenomenology of Husserl and certain Husserlian concepts that formed the framework of my study. The Husserlian approach towards phenomenology is described in eight steps. The chapter is concluded with a description of my own pre-understandings of the studied phenomenon of adolescent childbearing.

#### **3.2 UNDERSTANDING PHENOMENOLOGY**

Historically, the field of phenomenology was seen as the foundation of philosophy during the 20<sup>th</sup> century (Smith, 2013). Phenomenology may be viewed in the following two ways: (i) as a disciplinary field as part of philosophy; and (ii) as a movement in the history of philosophy led by phenomenologists such as Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty and others (Smith, 2013). Traditionally, phenomenology is seen as the approach searching for the meaning of every-day events, objects or experiences of people's lives and defining the significance of these things (Smith, 2013). It is a continuous attempt to understand people's experiences without speculating about the meaning or significance thereof, but rather to describe it based on their stories (Sawicki, 2011). Every human action,

gesture or habit has a meaning through intentionality<sup>9</sup> because there is a consciousness about every action, gesture or habit.

Sadala and Adorno (2002:283) stated that 'without consciousness there is no world and without a world there is no consciousness.' Therefore consciousness is seen as 'the agent that attributes meanings to objects' (Sadala & Adorno, 2002:283). Meaning is attributed to an object or experience in an attempt to describe the significance or essence of that object or experience. It is the researcher's role to explore people's experiences of a certain phenomenon. The researcher then studies the information, interprets the meaning of those experiences and attempts to describe and understand the essence of the studied phenomenon.

It is important to reflect on various experiences in order to study conscious experience. In other words, people do not always attach meaning to an experience at the time they are actually experiencing it. Often people go through an experience without being able to identify their emotions straight away (Smith, 2013). They prefer to create a conscious memory of the experience by associating it with things that are familiar to them. In other words, a person will describe an experience in terms of the feelings he or she experiences; for example, when he or she sees a sunset or hears a specific song, since these things are familiar to him or her (Smith, 2013). Many of a person's intentional mental actions are performed without thinking about them at all. However, when prompted to consciously reflect on some experiences, he or she may identify certain feelings and thoughts about the experience that he or she was not aware of at the time (Smith, 2013).

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<sup>9</sup>. Intentionality refers to 'the human mind reaching out and into the objects of which it is conscious' (Crotty, 1996:38).



The goal of phenomenological research is to apply different methods to access the essence<sup>10</sup> of a certain phenomenon. This process provides the researcher with the details of the experience from the subject's viewpoint (Jasper, 1994).

### **3.3 EDMUND HUSSERL**

Edmund Husserl (1859 - 1938) was a German philosopher known as the 'father of the discipline of phenomenology,' a movement that started as a segment of the field of philosophy (Sawicki, 2011:1). Husserl was one of the most influential philosophers of his time (Sawicki, 2011). While lecturing in psychology he started working on the definitive formulations of his phenomenology (Sawicki, 2011). Although it was a fairly new concept in his time, it was not a new practice. Epistemologists and ontologists before Husserl's time practised phenomenology when they characterised people's 'states of perception, thoughts and imagination' (Smith, 2013:8). In modern philosophy, analysts study problems of consciousness<sup>11</sup> and intentionality, therefore also using phenomenological practice. Husserl named this practice of reflecting on consciousness and intentionality, phenomenology.

#### **3.3.1 The Phenomenology of Edmund Husserl**

Husserl became famous for developing transcendental phenomenology<sup>12</sup> (McConnell-Henry, Chapman & Francis, 2009). When phenomenology was described as an alternative movement to the positivist paradigm, Husserl

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<sup>10</sup> Essence refers to characteristics of a phenomenon that are 'absolute and universal and will never change over time' (Jennings, 1986: 1232).

<sup>11</sup> Consciousness refers to the recognition of one's own state of mind by thinking about one's state of mind or being aware of one's state of mind (Siewert, 2006).

<sup>12</sup> Transcendental phenomenology is the term used to describe 'essential structures that allow the objects naively taken for granted in the 'natural attitude' to constitute themselves in consciousness' (Beyer, 2015:1).

took it one step further. Feeling disillusioned by the natural sciences that studied human experiences, Husserl developed transcendental phenomenology and introduced the concept of lived experiences for the first time (McConnell-Henry, Chapman & Francis, 2009; Chapman & Werner-Wilson, 2008). Husserl encountered some criticism from fellow phenomenologists (Heidegger, Sartre, Merleau-Ponty) who suggested that his transcendental phenomenology focused more on idealism and that Husserl abandoned his realist standpoint. Husserl defended his 'transcendental-phenomenological idealism' by arguing that it attempted to make sense of the world as people know it through experience and that it did not deny the existence of the actual world (Sawicki, 2011:4).

Husserl primarily focused on the theory of knowledge (epistemology). He concentrated on consciousness and knowledge, believing that 'to know is to see' (McConnell-Henry, Chapman & Francis, 2009:10). His phenomenology is descriptive in nature and attempts to raise awareness of the intentionality or consciousness towards certain phenomena (McConnell-Henry, Chapman & Francis, 2009).

At its core, the movement of phenomenology aims to study and describe experiences from a first-person perspective. These experiences range from 'perception, thought, memory, imagination, emotion, desire and volition to bodily awareness, embodied action and social activity including linguistic activity' (Smith, 2013:2). Husserl described these kinds of experiences as intentionality – having a consciousness about something or a person's internal experience. Husserl referred to people's experiences of 'things in the world' as their *life-worlds*, which relates to how they experienced certain phenomena (Smith, 2013:2).

### **3.3.2 Husserlian Phenomenological Approach**

The Husserlian method to explore the life-world and experiences of people consists of eight steps. These eight steps were followed during the research (Burns & Grove, 2009):

1. The researcher explores the diversity of his or her own consciousness.
2. The researcher reflects on experiences and chooses a phenomenon to study and develops a research question and phenomenological framework.
3. The researcher brackets his or her own pre-understandings.
4. The researcher goes out in the field and explores the experiences of participants by conducting conversational unravelling.
5. The researcher uses descriptive unravelling to explain information.
6. The researcher explores clusters of themes to validate the meanings with the phenomena being studied.
7. The researcher uses bracketing and reflection to grow the phenomenon and findings by integrating the bracketed pre-understandings into the unravelling process.
8. The researcher uses the findings either to make recommendations or for new research (Burns & Grove, 2009: 530).

### **3.3.3 Husserl and Bracketing**

Husserl introduced the concept of *noema*. This concept refers to the perceived experience a person has of a certain phenomenon (Smith, 2013:7). Husserl believed that the only way to get to the essence of a phenomenon and to describe the lived experience is to put aside any preconceived ideas about the phenomenon. Husserl created the term *epoche* to describe this concept. *Epoche* is the Greek word for the term bracketing (Smith, 2013; McConnell-Henry, Chapman & Francis, 2009).

Having achieved a doctorate in mathematics at the age of 24, Husserl decided to move on to study psychology but his mathematical background still influenced his practice of phenomenology when he developed bracketing. With his introduction of bracketing, Husserl attempted to gain as much objectivity about a phenomenon as possible, believing that putting aside preconceived ideas - in other words to bracket these ideas and set them aside - will give the researcher purer insight into the essence(s) of the lived experiences (McConnell-Henry, Chapman & Francis, 2009).

Husserl introduced bracketing or phenomenological reduction for the first time in phenomenology. In the same way that a mathematician will distinguish certain mathematical equations from others by putting them in brackets, the Husserlian methodology requires researchers to bracket their own pre-understandings<sup>13</sup> and assumptions separately from the participants' experiences. This principle of bracketing demands the following from the researcher: (i) to visit his or her own pre-understandings about the study that he or she is conducting; (ii) to be aware of these pre-understandings; (iii) to acknowledge the emotions these pre-understandings bring forward; and then (iv) to set these pre-understandings aside and approach the participants and the information with an open mind, free of pre-understandings (Hamill & Sinclair, 2010).

According to Husserl, researchers should bracket the question of the natural world's existence around them, therefore focusing their attention inwards and reflecting on their own experiences. This then leads to the realisation that each and every act of consciousness is intentional and directed towards

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<sup>13</sup> Pre-understandings or presuppositions (previously referred to as assumptions) are certain ideas assumed about something beforehand or before action is taken (Oxford University Press, 2015i). Applied to phenomenology, pre-understanding means to assume certain ideas about a phenomenon before more information and understanding is gathered about the phenomenon.

something based on a person's perception or thoughts about that object (Smith, 2013; Sawicki, 2011).

Husserl argued that phenomenology is not an approach of generating a theory by using extrapolation. Rather, the researcher would have to look at certain examples of the phenomena without any pre-understandings before they can derive meaning from the information (Sawicki, 2011:1). In other words, the researcher needs to bracket his or her own pre-understandings to be able to better understand the phenomenon without prejudiced or biased emotions.

### **3.4 MY PRE-UNDERSTANDINGS**

Using Husserl's position on bracketing, I found it useful as a novice researcher to bracket my own pre-understandings of adolescent mothers' childbirth experiences. I divided my pre-understandings into three paradigms and described them as ontological, epistemological and methodological pre-understandings.

#### **3.4.1 Ontological Pre-understandings**

Crotty (1998:10) describes the concept of ontology as the 'study of being' by referring to the natural world of existence. Guba and Lincoln (1989:83) regard ontological pre-understandings as addressing your own understanding of the phenomenon's nature of existence. I bracketed my pre-understandings of adolescent mothers' natural world of existence prior to starting the fieldwork of this research.

In my experience with adolescents and their behaviour, I came to the conclusion that they are too young to be mothers. They are still children

themselves and suddenly have to assume the responsibility of looking after another human being and keeping another human alive and healthy. They do not know anything about parenting and lack insight into any skill, responsibility or method of parenting, meaning that they are going to have to figure it out as they go along. They are usually not prepared for labour or childbirth and find it difficult to cope with all it entails. When they are admitted to the hospital or clinic, a definite teenage pregnancy stigma follows them wherever they go. Nurses and midwives tend to act as if it is their right to publicly reprimand these young mothers because of their age and to tell them how irresponsible they were to fall pregnant. The mothers are usually told how irresponsible they were, with the added comment, "WHO do you think is going to look after this baby now?" Usually the adolescents just keep quiet and listen to the midwives' verbal abuse without saying a word. I also noticed that the more judgmental a midwife is towards the patient, the more uncooperative the adolescent becomes.

### **3.4.2 Epistemological Pre- understandings**

According to Crotty, ontology closely relates to epistemology. He defines epistemology as 'what it means to know' (Crotty, 1998:10). Epistemology refers to knowledge and how we acquire that knowledge; alternatively described by Crotty as 'how we know what we know' (Crotty, 1998:8).

When it came to interventions, especially invasive procedures such as vaginal examinations, episiotomies or assisted deliveries, the adolescent mothers seemed to require a considerable amount of explanation of and assistance with the procedure. At the same time, it appeared as if an adolescent mother was not always allowed to make her own choices. Suggestions that the midwives or doctors made regarding her care were usually fully supported by her birth companion, who was usually her own

mother. The mother would tell her that she had to listen to them since they knew best.

In addition, when an adolescent patient did not know or did not trust the midwife or doctor looking after her, she also seemed to not cooperate. It happened more than once that one midwife consigned an adolescent mother to another as being “very difficult and uncooperative”. The adolescent mother then gave birth without problems, fully cooperating with the new midwife.

### **3.4.3 Methodological Pre-understandings**

My methodological pre-understandings were that a qualitative phenomenological study would enable me to explore the phenomenon - I believed that conversing with the adolescent mothers who underwent a normal (vaginal) childbirth, would allow me to learn more about their experiences. By having a phenomenological conversation with them, I hoped to explore some of my pre-understandings that fear of mistreatment by the nursing staff may influence their behaviour and experience. It appeared as if adolescents became more uncooperative when they were more scared of or intimidated by the midwife. Therefore I hoped to gain more insight into the attitudes of the caregivers (in this case the midwives) towards the adolescents and whether it had positively or negatively influenced their experiences of giving birth.

## **3.5 CONCLUSION**

This chapter was presented to provide the reader with a general description of Husserl’s phenomenology that formed the foundation of this research. The

methodology, design and expansion of the Husserlian approach of the study are discussed in the next chapter.



## **CHAPTER 4**

### **RESEARCH DESIGN AND METHODS**

#### **4.1 INTRODUCTION**

A qualitative research design using Husserl's phenomenology was chosen for this study. The Husserlian approach aims to understand people's perceptions, interpretation and understanding of a certain event or situation, exploring these perceptions and describing the phenomenon (Leedy & Ormrod, 2005).

This chapter describes the chosen design and the methods that were used to obtain information. The chapter is structured by introducing qualitative methods and a phenomenological approach, followed by broadly describing the methods of participant invitation that were followed (sections 4.3.1 to 4.3.3). The inclusion and exclusion criteria are then presented. The process that was followed to unravel the information is subsequently described in accordance with Colaizzi's seven steps (section 4.3.4). The chapter is concluded by a detailed explanation of the trustworthiness and ethical considerations of the research (sections 4.4 and 4.5).

#### **4.2 RESEARCH DESIGN**

The qualitative design and phenomenological approach that guided the methodology of the study is presented in sections 4.2.1 and 4.2.2.

##### **4.2.1 Qualitative Research**

The methodology of qualitative research focuses on serving specific types of research questions, aiming to understand the specific phenomenon under investigation (Leedy & Ormrod, 2005). These questions are generally open-

ended and researchers proceed with the research from a point of using general methods to gather information, to moving towards more suitable and specific methods as they learn more about the phenomenon.

Mason (2002:4) explains qualitative research as 'exploratory, flexible, driven by data and sensitive to context'. Additionally, when one wants to explore people's lived experiences and understand their life stories and everyday behaviour, a qualitative research design is more appropriate than a quantitative design. Hence a qualitative design was used in this study, following a phenomenological approach (Silverman, 2010).

#### **4.2.2 Phenomenological Approach**

The phenomenological approach explores and interprets the meaning that people give to specific events that happen in their lives (De Vos et al., 2005). Information is gathered about a phenomenon in a specific context, after which meanings and themes of the experiences are derived and explored.

The specific phenomenological approach that I have used was that of Edmund Husserl. The Husserlian method to explore the life-world and experiences of people consists of the eight steps below, which were followed during the research (Burns & Grove, 2009).

1. I explored the diversity of my consciousness until I found a particular phenomenon I wanted to study – adolescent mothers.
2. I reflected on experiences I had and chose a phenomenon to study – adolescent mothers' childbirth experiences - and developed a research question and phenomenological framework.
3. I bracketed my own pre-understandings about the phenomenon I researched under ontological, epistemological and methodological pre-understandings.

4. I explored the experiences of participants by engaging in conversations with them.
5. I summarised and described the information I gathered from participants.
6. I explored clusters of themes to validate the meanings with the phenomena I studied.
7. I used bracketing and reflection to fill out the phenomena and findings by integrating the bracketed pre-understanding into the information unravelling.
8. I used the findings to make recommendations.

### **4.3 RESEARCH METHOD**

The research method describes the study setting, invitation of the participant, as well as the methods used for information gathering and unravelling.

#### **4.3.1 Study Setting**

The participants were approached in postnatal wards, which are maternity wards in the hospitals, where mothers and babies stay together after the birth until they are discharged. The hospitals all have two different postnatal wards; one for mothers who gave birth naturally and another for mothers who gave birth by caesarean section. The participants who were approached and invited for this study all came from the former. The public sector referral hospitals that were used for this study were both situated within a 20 km radius from the City of Cape Town.

The Human Research Ethics Committee (HREC) of the Faculty of Health Sciences of the University of Cape Town granted ethical approval (appendix A) to conduct the study. The Western Cape Government Health Department

(appendix B) granted permission to conduct the research in provincial health facilities. The hospitals were approached to source potential participants.

Two public referral hospitals were used to approach and invite potential participants to participate in the study. The choice of setting was based on the following:

- according to the Guidelines for Maternity Care in South Africa (Department of Health, 2007), 16 years of age and below is considered a risk factor for pregnant females and therefore requires births to take place in a secondary hospital;
- the referral hospitals serve a wide catchment area; thus the participants reflected a socio-culturally diverse profile of the Western Cape;
- hospitalised patients were kept for 24 hours post-partum before they were discharged home. This provided me with adequate time to approach potential participants, explain the research thoroughly to them and to answer questions. Furthermore it gave me plenty of time to find the participants the following day for the scheduled conversations; and
- the invitation of potential participants in the study setting was feasible since participants could be approached on weekdays as well as over weekends and holidays because there was a constant flow of patients through the hospitals.

#### **4.3.2 Population and Participant Invitation**

The population of the research is described in this section as well as the invitation of potential participants to participate in the study, which was done according to a set list of inclusion and exclusion criteria.

#### 4.3.2.1 Population

The population consisted of middle adolescent girls from 14 to 16 years of age who had given birth. A purposive sampling method was used.

#### 4.3.2.2 Inclusion Criteria

- Adolescents were aged 14 to 16 years at the time they gave birth
- English- or Afrikaans-speaking participants, as these are the two languages in which I am fluent as the researcher. (This is discussed further in section 4.5 – Ethical considerations.)
- Adolescents who had a normal vaginal birth of a singleton pregnancy
- Barring the age as a risk factor, a low-risk pregnancy at 37 completed weeks of gestation<sup>14</sup> or more
- Gravida<sup>15</sup> 1 Para<sup>16</sup> 1 ( G<sub>1</sub>P<sub>1</sub>) postpartum
- Adolescents who had one or more antenatal visits
- Birth that resulted in a live infant.

Although there were quite a number of adolescents who fell in the age category, many were not eligible for the study due to modes of delivery other than normal vaginal births and gestational ages less than 37 weeks.

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<sup>14</sup> See definitions

<sup>15</sup>Gravidity refers to the number of pregnancies a woman has had, including the current pregnancy (if applicable) and any miscarriages or ectopic pregnancies (Cronjé, Cilliers & Pretorius, 2011).

<sup>16</sup>Para (Parity) refers to the number of 'viable fetuses a woman had given birth to including stillbirths' (Cronjé, Cilliers & Pretorius, 2011:57).

#### 4.3.2.3 Exclusion criteria

- Early neonatal death<sup>17</sup>
- When the adolescent mother gave the baby up for adoption
- Obstetric emergencies such as obstetric haemorrhage, shoulder dystocia and cord prolapse.
- Complications during postpartum period such as
  - postpartum haemorrhage
  - retained placenta
  - maternal resuscitation
  - perineal tears - third and fourth degree - to be repaired in theatre (not including first and second degree tears or episiotomies)

The exclusion criteria were chosen based on the premise that an obstetric complication requires immediate medical intervention and can be life-threatening. The interventions required may influence a woman's experience of birth significantly, as they can vary from minor invasive procedures to major operative procedures.

#### 4.3.2.4 Sample Size

A sample size of six to eight participants was intended. Saturation of data was reached after conversations were held with six participants. The time

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<sup>17</sup> Early neonatal death refers to the 'death of a baby that falls within the period from birth to a full six days of life' (Cronjé, Cilliers & Pretorius, 2011:744).

period for information gathering was extended, since many participants did not return for the initial scheduled conversations; thus information saturation was not reached within the expected fieldwork period of three to four months (Burns & Grove, 2009). In total, 13 adolescents were approached and invited to participate in the study; in the end six adolescents participated in my research. Hale and Kitas (2008:91) maintained 'that true data saturation can never really be achieved' and that the aim of phenomenology is to gather 'full and rich personal accounts from the sample used'. These six conversations offered rich information on the phenomenon and no more participants were required.

#### 4.3.2.5 Participant invitation

After permission was obtained (appendices B and C) to conduct the study in two hospitals (see section 4.3.1 for details), permission was also obtained to facilitate the conversations in a specific venue at the hospital over weekends when the participants were not attending school. Over a period of seven months, all eligible adolescents were approached and invited to participate in the study. Participants participated in the research on a voluntary basis. During these visits I informed them about the study and explained the participation requirements. As the participants were minors (that is, not yet 18 years old), the parents or legal guardians' consent was needed (appendix D), as well as assent from the adolescents (appendix E) to participate in the study. If the adolescent was interested in participating, her permission was obtained to contact her parents/legal guardians regarding the study.

Contact was made with the parent/legal guardian by means of cellular calls or during visiting time at the hospital. Additionally I approached a few participants shortly after they had given birth and whose parents were still visiting. I used the opportunity to address both the participant and her

parents/legal guardians. Only once the parent/legal guardian had given consent, did I obtain assent from the adolescent herself to participate in the study. The adolescents and their parents/legal guardians were informed that the conversations will be audio-recorded and consent was also obtained for this. In addition, the adolescents were informed that if they wished to withdraw from the research that they could do so without their care being affected or any negative consequences.

#### **4.3.3 Information Gathering**

All 13 adolescents I approached agreed to participate, but in the end only six adolescents participated in the study. An initial conversation was held with all of them after they had given birth. The potential seventh participant's conversation was terminated after seven minutes, since the participant indicated that she no longer wanted to participate because she was discharged and her mother had arrived to take her home.

Initially the conversations with the participants had been planned to take place two to three weeks after giving birth. However, this was changed during the field work as potential participants would agree to the research but would not return for the scheduled conversation and be unavailable on their cell phones. Other potential participants agreed to participate in the research but either did not have someone to look after the baby at home or did not have transport to the hospital. In light of the above, a motivation to change the timing of the initial conversation was filed and approved by the HREC of the Faculty of Health Sciences of the University of Cape Town (appendix F). Permission was granted by the HREC to initiate the first conversation within 72 hours after giving birth, before the participants were discharged.



My motivation for choosing the new timing was that the initial conversation could be held as soon as possible after birth while the memories were still fresh and the participants could remember more details and recall the feelings they experienced during childbirth. Rapport was also established throughout the first interview, which motivated the participants to return for the follow-up conversation.

In-depth semi-structured phenomenological conversations were held within 72 hours after giving birth. A conversation lasted between 15 and 40 minutes. A reflective drawing was used to initiate and assist with the phenomenological conversation. The intended length for these conversations was approximately 60 minutes; however, the participants needed significant probing and encouraging to elaborate, seeing that their responses were generally short and often repetitive.

After the initial conversations, only three participants returned to the hospital within three weeks for a short follow-up conversation. During the follow-up conversation, the clusters of themes derived from their experiences were presented and explained to them. During these conversations they had an opportunity to add more information and/or to rectify any misinterpretations I might have made regarding their experiences.

People's telling of their personal experiences or stories is a way of knowing and learning about them. Researchers interview people because they are interested in the stories people have to tell (Seidman, 1998). The interview skills of the researcher are important in qualitative research, as the quality of the information gathered during the interview depends mostly on the competency and skill of the interviewer (De Vos et al., 2005).

#### 4.3.3.1 Drawings

For this study, the drawings were used as ice breakers and to provide focus during discussions. Drawings can bring to light additional information that might not be verbalised and reflect a person's state of mind, even though he/she cannot translate this into words (Oster & Crone, 2004). For this reason a drawing was used during the interview to keep the focus on the phenomenon being researched and as an aid for the participant to continue the conversation.

A drawing can offer a person a non-verbal chance to express feelings or thoughts that he/she may not have been aware of before. Drawings of past events are commonly used in therapy and are perceived as less threatening for clients who may have been traumatised (Oster & Crone, 2004). However, the use of drawings in this research served solely as a point of departure in the conversation and to keep the focus on the topic at hand.

The participant was expected to draw a reflective drawing, initiated by the following request: *"Please draw what happened in the labour room when you gave birth"*. The phenomenological conversation was initiated after the drawing has been completed by asking the participant: *"Please tell me about your drawing"*. Although most of them were reluctant to draw due to fearing a lack of artistic skills, they all immediately started drawing when a paper was put in front of them.

#### 4.3.3.2 Conversational skills

I have completed training in group and individual interviews during my psychiatric nursing training and am qualified and confident to lead a therapeutic conversation and to facilitate interviews. Additionally, I have

attended workshops on communication skills and interpersonal relationships and how to understand adolescents' behaviour. I have furthermore attended seminars on adolescent approaches and listening skills when working with adolescents. I have been assessed on many occasions during and after training and found to be competent to conduct interviews on all occasions.

During the phenomenological conversation, I used vocabulary that was familiar to the participants (Rubin & Rubin, 2005). During the phenomenological conversations I made field notes of observations I made during the conversation, which was also used as information. I used certain techniques during the conversations to encourage the participants to keep talking, such as nodding of the head, making sounds to show my interest and asking probing questions about their experiences. Occasionally, when participants were distracted by their babies or their cell phones, I used the drawing to draw their attention back to the conversation by asking about the details in the drawing. Additionally I commented on what I have observed during the conversation and asked the participants to elaborate on specific comments they have made during the conversation. During the conversations I summarised their narratives briefly in order to ascertain that I grasped the essences of their experiences (Burns & Grove, 2009).

#### 4.3.3.3 Methodological pre-understandings

Since I am a novice researcher, I was using phenomenology for the first time as a methodology. I have no personal experience of childbirth, but have worked with adolescent patients and have been present at many of their births as a midwife and observer. In order to distinguish between research findings and researcher bias, I used bracketing (also known as phenomenological reduction) as described by Husserl (Smith, 2013; Tufford & Newman, 2012; Hamill & Sinclair, 2010; Ahern, 1999). I kept a reflective journal throughout the research and recorded any thoughts, feelings or

subjective observations in the journal to contain my own bias about the research.

#### **4.3.4 Information Unravelling<sup>18</sup>**

The methods that were used to unravel the information that was gathered from the conversations are described in detail in this section.

##### **4.3.4.1 Audio-recorded conversations**

All the conversations were audio-recorded and transcribed verbatim afterwards. I did all the transcribing of the conversations and no one else but my supervisor (for validation purposes) had access to the recorded conversations. The participants who seemed uncomfortable beforehand about their voices being recorded ultimately forgot about the recorder once we started conversing.

The meanings and interpretations of the initial conversations were taken back to the participants and explained to them; the follow-up conversations were also audio-recorded. Once they agreed that the descriptions were accurate, I initiated another conversation, but most of the girls had very little to add and were satisfied with the content.

Only three participants were available for the follow-up conversations. One participant was not interested to return for a follow-up conversation and the other two participants could not be reached for a follow-up conversation,

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<sup>18</sup> To unravel is to 'undo twisted, knitted or woven threads' in order to simplify something and phenomenological speaking to grasp the essence and meaning of a phenomenon (Oxford Dictionary, 2015j:1).

even though I attempted to make contact for three months. Nine conversations were held in total.

I used a seven-step phenomenological unravelling method as described by Colaizzi (Colaizzi, 1978). These steps enabled the unravelling process indicated in the Husserlian method described in section 4.2.2. Three key concepts of Husserl's work guided the formation of the themes. These concepts were *essences, intentionality and consciousness, and life-world*. These concepts formed the framework of the themes and subthemes during the unravelling process, as follows: i) the essences of the adolescent mothers' experiences of childbirth; ii) their intentionality and consciousness towards childbirth, and iii) their life-world experiences during childbirth. The seven steps of Colaizzi were followed as described below.

1. I read through all the conversations as many times as were needed to get a general idea of what was said.
2. I then studied each individual conversation, searched for significant statements made by each participant and wrote them down.
3. I formulated a meaning for each significant statement I have written down.
4. The formulated meanings were divided into clusters of themes. The sub-themes and essential meanings were grouped according to the key concepts of Husserl's approach.
5. The clusters of themes were all organised into one exhaustive description of the participants' experiences.
6. The exhaustive description was summarised into a conclusive and validated statement to give the clearest picture of their childbirth experiences.
7. Validation of the meaning of the experiences was done by taking the results and statements back to the participants to review my findings and to correct any misinterpretations I had made.

During the follow-up conversation I explained and validated the meanings of the previous conversation and discussed the explored clusters of themes with the participant. This was done in order to i) clarify any misinterpretations I may have made regarding their experiences; and ii) to create an opportunity to gain additional information if the participant added to the themes and clusters.

#### 4.3.4.2 Field notes

Field notes were made based on the premise that they focus on the non-verbal aspects of the conversation, while the audiotape focuses on the verbal aspects. I refrained from making any field notes during the conversations; however, immediately after the conversations I made field notes about my observations during the conversations. The focus during the conversations was on the content of the conversations and distractions were kept to the minimum. Afterwards I incorporated each conversation's field notes in the transcript of the conversation by adding notes about the participant's non-verbal behaviour.

#### 4.3.4.3 Reflective journal

The reflective journal that I kept throughout the study turned out to be more than just a reflection on the study. I noticed that feelings surfaced of which I was not aware of previously. The field work was very challenging, since I could not always rely on the participants to return for conversations or show up for scheduled appointments. This caused me some frustration and anger during the study and the reflective journal was an aid to bracket all my feelings about the study or the participants and to leave those behind before I

engaged in the next conversation. Some extractions from the reflective journal are shared in chapter 6 - Discussion of themes.

#### 4.3.4.4 Independent coder

An independent coder was used to review the sub-themes and essential themes based on the conversations and to verify if the gathered information supported the identified themes. The information was provided confidentially to the independent coder who identified her own themes and compared these to my themes afterwards. Although headings and sub-headings were clustered differently between the independent coder's notes and my own, the identified themes remained consistent between the two comparisons. Refer to appendix G for the presentation of the independent coder's themes.

## 4.4 TRUSTWORTHINESS

Trustworthiness refers to the rigour of a study that is concerned with the quality, stability, repeatability and the accuracy of the research process. (Brink, Van der Walt & Van Rensburg, 2012). The value of trustworthiness is that it acts more as a guideline for the researcher than a criterion. Trustworthiness requires the researcher to commit to presenting truthful information on paper (Porter, 2007). The means to ensure rigour in qualitative research comprises different aspects of the truthfulness of the study and have been divided into categories of credibility, transferability, dependability and confirmability (Babbie & Mouton, 2006).

#### **4.4.1 Credibility**

Babbie and Mouton (2007) describe credibility as the consistencies between the existing realities in the studied phenomenon and the realities that the researcher attributes to the phenomenon.

I used various methods and materials to gather information and to produce a more accurate and comprehensive representation of the phenomenon (Silverman, 2006).

- Referential adequacy refers to the materials used in a study to document the findings (Babbie & Mouton, 2007). Only audiotaping of the conversations was used as a measure of record keeping and not videotaping, to ensure the anonymity of the participants. I, myself transcribed the conversations verbatim and my supervisor verified these for accuracy.
- Peer review refers to a peer outside the study, who is an expert in the method being used, reviewing the information unravelling process and supervising when information is coded into themes and categories (Brink, Van der Walt & Van Rensburg, 2012). My supervisors performed the peer review; they provided me with assistance during the process of information unravelling and the formation of the themes within the Husserlian framework.
- Member checking refers to the gathered and unravelled information being taken back and presented to the participants to clarify whether the information and the meanings derived from the information are correct (Babbie & Mouton, 2007). In addition to Colaizzi's steps, the credibility of this study was ensured by taking the themes back to the participants and validating the identified themes with them. Even though only three participants were available for member checking,



the meanings were validated with them and no adjustments were required from their side. In addition, I made summaries during the initial conversations that they could confirm at that time in order to ensure that I understood them correctly.

#### **4.4.2 Transferability**

Transferability refers to the ability to transfer the conclusions of this study to a similar study done in a different context and with different participants (Brink, Van der Walt & Van Rensburg, 2012). Transferability in qualitative studies might prove difficult to generalise to every other setting or phenomenon in qualitative research (Shenton, 2004). The findings of this study cannot be generalised for other middle adolescents and their childbirth experiences, however, the research process I adopted may be used by other researchers in order to obtain their own findings. For this reason, a detailed description of the context of this study, participant selection and methodology was provided. A detailed description of the Husserlian framework that guided the study was presented in order for the reader to understand the methodology that was followed and to be able to repeat the steps in his/her own research if necessary (Shenton, 2004).

#### **4.4.3 Dependability**

Dependability refers to the external auditing of the information by a researcher who is not involved in the current research. The external researcher evaluates the findings for accuracy and whether it is supported by the gathered information (Guba & Lincoln, 1985). The independent coder involved in my study is a researcher who is familiar with phenomenology and psychiatric nursing and who has completed master's and doctoral

research in the field of psychiatric nursing using a phenomenological framework.

The independent coder worked independently from me and tested the dependability of the information by unravelling the gathered information independently. I met with the independent coder afterwards to look for consistency. We compared the information, the findings, the interpretations and the recommendations which we had developed independently. During these sessions we assessed if our findings were supported by documented data, in order for the study to be accepted as true to reality (Babbie & Mouton, 2006). Although different headings were identified by the independent coder, the content was similar to my findings and therefore the independent coder's input was considered in the identification of the themes.

#### **4.4.4 Confirmability**

Confirmability refers to the audit trail that a researcher has to produce throughout his/her research in order for the reader to follow the steps of the research process (Babbie & Mouton, 2006). The reader should be able to comprehend how the researcher arrived at his/her conclusions and should be able to confirm to what degree the results are the product of the study or the researcher's biases (Babbie & Mouton, 2006).

During this research, I documented all information, raw and analysed; in this case recorded conversations, transcribed conversations, drawings and field notes. I also kept a reflective journal throughout the study in which I continuously bracketed my own feelings and thoughts about the research (presented in chapter 6). All this information is now kept secure so that it can be followed up and to protect the information gathered. Fellow researchers or readers of the study can trace the audit trail should they want to confirm

my findings and objectivity. This information will be kept for a period of three years after the study has been published.

## **4.5 ETHICAL CONSIDERATIONS**

I followed the ethical principles of the Declaration of Helsinki (World Medical Association, 2013) regarding medical research on human subjects. I promoted and safeguarded the health of the participants, with the well-being of the participants being my first priority. I submitted this research protocol to the Faculty of Health Sciences Human Research Ethics Committee at the University of Cape Town before the study commenced and received ethical approval to conduct the study – HREC 256/2014 (appendix A).

The hospitals were government facilities and, in order to conduct any recruitment or study, I sent a letter to the hospitals' managers to inform them about the study, the intentions I had and the recruitment process I needed to follow. The Provincial Government granted permission to conduct the research in the province and at the first referral hospital; the second referral hospital subsequently granted permission to use their facilities to invite participants (Appendices B and C).

In accordance with the principles of the Declaration of Helsinki, certain aspects of the ethical considerations that were applicable to this research are addressed below.

### **4.5.1 Principle of Respect for Persons**

The principle of respect for persons is divided into two sections: confidentiality and autonomy.

#### 4.5.1.1 Confidentiality

It was not possible to keep the participants' identities completely anonymous during the participant invitation process. The participants were invited according to the inclusion criteria, and the research method required an in-depth conversation with them. Since I have conducted my own fieldwork, the participants' identities are known only to me. In order to conduct follow-up conversations, I needed to identify their data and contact details; therefore anonymity was not feasible although confidentiality was maintained. The identities of all participants were protected, except from me, by using aliases that they have chosen themselves.

#### 4.5.1.2 Autonomy

Autonomy of the participants was ensured through adolescent assent and voluntary participation.

##### 4.5.1.2.1 Permission for eligible participants

The research process differs when research involves children, since children below the age of 18 are considered to be minors according to the Children's Act No. 38 of 2005 (Children's Act, No. 38 of 2005, 2006).

Research involving minors requires minimal risk to the minors. It furthermore requires that the parent or legal guardian's consent to approach the minor must first be obtained. Only thereafter the minor's assent is required if he/she is able to understand what the research is about. Assent refers to the minor agreeing to participate in the research after consent has been obtained from the parent/legal guardian. However, even with consent

from the parent/legal guardian, no minor can be forced into participating in research (Department of Health, 2006).

#### 4.5.1.2.2 Voluntary participation

The participants of this study were minors; therefore the parent/legal guardian's consent was obtained, after which the adolescent's assent was obtained for participating in the study. In the case where the parent/legal guardian consented to the study but the adolescent refused, I respected the adolescent's autonomy, as participation in the study was voluntary (Brink, Van der Walt & Van Rensburg, 2012). I made it clear during the first contact with potential participants that should they refuse or discontinue their participation, they may do so without any negative consequences. Refer to appendices D and E for examples of information leaflets and consent and assent.

#### 4.5.2 Principles of Non-maleficence and Beneficence

In this study, it was anticipated that there would be no physical, spiritual, economic, social or legal intervention that could be harmful to the participants. However, since this study explored the emotional and physical experiences of participants, I recognised the possibility of causing emotional or psychological distress in participants by asking probing questions about their childbirth experiences. Indirectly the participants may have experienced the retelling of their experiences as therapeutic, which helped them to deal with the events, but at its core qualitative research risks exploring unresolved issues (Brink, Van der Walt & Van Rensburg, 2012).

The participants did not directly benefit from this research, except knowing that their contributions to the research may benefit future adolescent mothers

and possibly their care as well. I provided finances for transport back and forth from the hospital for the scheduled conversations, as well as refreshments. In addition I made provision for cots for the babies and organised private breastfeeding rooms for the young adolescents, since some of them had no one to look after the baby at home during the course of the conversations.

#### **4.5.3 Risks and benefits to participants**

According to the ethical principles described in the Declaration of Helsinki (World Medical Association, 2013), the researcher is obliged to assess the possible predictable risks and burdens to the participants. Risk reduction was considered during the course of my research. I considered the risk of causing possible emotional distress and had a referral system available to young mothers support groups at no cost to the participants, if participants wanted further support or had a desire to converse again. These support groups are organised and run by a lady who herself was an adolescent mother. These groups meet monthly in order for the adolescents to discuss any issues or concerns about anything from parenthood to going back to school.

#### **4.5.4 Principle of Justice**

I have recognised that language limited participation, but this was justified on the basis of the research approach. A translator was not used in this study, as meaning and interpretations are important in phenomenology, and nuances could be lost when translating from one language to another. Additionally, the translator might attach his/her own interpretation when translating, providing the researcher with a biased translation instead of the participant's exact words or meaning.

## **4.6 CONCLUSION**

This chapter described the methods that were followed to conduct the study. Nine conversations were held in total, including follow-up conversations. Participation in the research was on a voluntary basis and the participants were aware of the fact that they could withdraw whenever they wanted to; henceforth only three participants returned for the follow-up conversations.

Saturation of information occurred after six initial conversations have been held, and the process of unravelling started. A Husserlian framework guided the research process, while Colaizzi's steps of coding and information unravelling directed the unravelling process. Three essential Husserlian concepts were identified as the framework on which the sub-themes and essential themes were based: i) the essence of adolescent childbirth experiences; ii) the intentionality and consciousness of the adolescents during these experiences; and iii) their life-worlds experiences of childbirth as an adolescent mother.

This chapter serves as a detailed record of the research process that I followed. This was presented in order to afford the reader or any other researcher the ability to apply this research process to other study contexts in order to gather more information about middle adolescent mothers' childbirth experiences.

## **CHAPTER 5**

### **DESCRIPTION OF THE THEMES**

#### **5.1 INTRODUCTION**

In this chapter, the unravelling of the conversations with the participants is presented. The participants' backgrounds, as well as a description of each of them, are provided (section 5.2). The participant-researcher relationship is described in section 5.3. During the unravelling process (section 5.4), the seven steps of Colaizzi's method were followed (as described in section 4.3.4). The information was divided into themes and sub-themes to create meaning and an exhaustive description of the participants' lived experiences (section 5.5). The themes are presented according to the Husserlian framework in section 5.6. An over-arching theme was identified as the preservation of personhood (section 5.7). A detailed description follows with extracts from the conversations with the participants to demonstrate how the themes and sub-themes were identified (presented in section 5.8).

#### **5.2 DESCRIPTION OF THE PARTICIPANTS**

In this section the participants are introduced to the reader by means of brief descriptions of their backgrounds and a summary of every participant's labour and childbirth events.

##### **5.2.1 General Background**

The ages of the participants were as follows: one was 14 years old, three were 15 years old and two were 16 years old. Four of the girls were from the Coloured (mixed race) ethnic group and two of the girls were from Black



ethnic groups. One was from the Xhosa<sup>19</sup> group and the other girl was born and raised South African, but her roots were in the Democratic Republic of the Congo. There were no eligible participants from any other racial group. Four of the girls chose to have the conversations in English and two chose Afrikaans. All the girls lived in the Cape Town Metropolitan area.

The socio-demographic backgrounds of the girls were not explored in detail during this study, as the focus of the study was on their experiences during childbirth only. During the first introduction session, where the participants were approached, a few socio-demographic factors were briefly discussed. The girls had all attended school until right before the birth of their babies and all of them mentioned the desire to go back to school afterwards. All the girls were in relationships when they fell pregnant. However, one of them was no longer with the father of the baby when the baby was born. They were all still living with their parents and their mothers were mentioned as the babies' caregivers when they go back to school.

### **5.2.2 Introducing the Participants**

A short description is provided of each participant, portraying characteristics that were observed during the conversations as well as from her birth story.

#### ***Stacey*<sup>20</sup>**

A 15-year old girl and in grade nine<sup>21</sup>, Stacey was living with both her parents and was still involved with the father of her baby. She was a shy girl and was soft-spoken during the conversations. She was the only participant

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<sup>19</sup> See definitions

<sup>20</sup> Not their real names. The participants chose these names as aliases.

<sup>21</sup> In South Africa, this is the ninth year of schooling and the second year of secondary school.

who arrived for the initial conversation at two weeks post-partum, before the timing of the conversations was changed. Because of the rich information gathered from her conversation, she was included as a participant. Stacey went into spontaneous labour at home and was admitted to the hospital where she had laboured for a while before her baby boy was born. She recounted a negative experience of childbirth and remembered not receiving pain relief during labour, as well as being subjected to unfriendly nursing care. She did not like the midwife who delivered her baby and wanted someone else to assist her during the birth, but it did not happen. She was very unhappy with the nursing care she received in the postnatal ward and wanted to go home as soon as possible. Her mother supported her during labour and picked her up the next day when she was discharged.

### *Mavis*

Mavis was 15 years old when she gave birth to her baby boy. She was in grade nine and was living with her parents. She was an outspoken girl who was not afraid of saying how she felt. Mavis had spontaneous rupture of membranes the day before and she was admitted to hospital. When she did not go into spontaneous labour by the next day, her labour was induced with intravenous medication. She was transferred from one ward to another during this time and eventually she was admitted to the labour ward. She received Morphine during labour for pain relief and was affected by the sedative effects; speaking incoherently and feeling confused during labour. She reported an overall negative birth experience and had to stay an extra two days in hospital after the birth of her baby in order to finish a course of antibiotics. The course of antibiotics was started when she did not go into spontaneous labour after her membranes ruptured, in order to prevent infection. Her mother was her support person during the birth.

### *Unathi*

Unathi was 16 years old at the time of the birth and in grade ten. She lived with both her parents, her father being the breadwinner in the house. Unathi described a conflicting relationship with her mother before she fell pregnant and how close they became during the pregnancy and the birth. She was soft-spoken during the conversations and seemed much older than her 16 years when she spoke about the feelings she experienced and the insights she gained during childbirth. She went into labour at home without realising that she was in labour. Eventually her mother noticed that something was wrong and decided to phone her father at work. He came home to take them to the clinic. From the clinic she was transferred to the hospital (reason unclear), where she gave birth soon after arrival. Unathi had a positive birth experience and had been very happy with the treatment she received from the nurses; specifically the midwife who delivered her baby girl. Unathi's mother had been with her throughout, except when she gave birth. Due to some miscommunication her mother was still waiting outside while Unathi was transferred into the labour ward. Despite her mother's absence, Unathi reported a good experience during birth as well as in the postnatal ward.

### *Cindy*

Cindy was in grade nine and was a spontaneous 16-year old girl who spoke easily about her birth experience. She recounted her reluctance to attend the family-planning clinic, and how she should have. She described how shy she felt being a pregnant adolescent among all the adults around her. Having gone into spontaneous labour at home, she did not want to go to the hospital immediately and waited until the next morning before she went to the clinic. From there she was transferred to the hospital because of an elevated blood pressure. According to Cindy's file, her elevated blood pressure had probably been labour-related and she was not treated for blood pressure

complications, since it was resolved once she gave birth. She was alone in hospital and wanted her mother to be there with her. However, she reported a positive birth experience because of the friendly treatment she received from the nursing staff, as well as from the midwife who assisted her during the birth of her baby. She was very relaxed during the conversations and recounted how she felt like a mother when she held her baby girl in her arms.

### *Farrah*

At 14-years old, Farrah was the youngest of all the participants and in grade eight in school. She is a confident girl who spoke openly about her feelings and her thoughts about the treatment she received. She is a quick thinker and spoke quickly and directly during the conversations. She never once sat down during the conversations, but stood the entire time. Farrah went into spontaneous labour at home. She went to the Midwife Obstetric Unit (MOU), but was transferred to the hospital because she was underage. She had been very unhappy at the MOU and felt relieved to be transferred. At the hospital she was soon rushed to the labour ward where she delivered her baby boy. Farrah was a very religious girl who spoke about praying through labour and thanking God that she had a safe birth with a healthy baby. Her mother had been with her during the entire process. Farrah felt unhappy about the mistreatment she received from the nurses on arrival at the hospital, but very satisfied with the midwife who assisted her during the birth of her baby.

### *Aquila*

Aquila was the oldest participant. At 16-years old, she was about three months away from her 17<sup>th</sup> birthday and in grade 10 at the time. She was from the Democratic Republic of the Congo (DRC) and had been living with

her mother and grandmother in South Africa for a few years. Her father was still living in the DRC. Aquila's labour started spontaneously and she was admitted to the hospital where she laboured. Even though she had her mother as support person, she struggled with the contractions during labour and did not receive pain relief. She had a negative experience of labour and the birth, and remembered a lot of shouting directed at her without knowing why. She gave birth to a baby boy soon after with the help of a friendly midwife, and felt very happy and relieved that everything was over.

### **5.3 PARTICIPANT-RESEARCHER RELATIONSHIP**

All the possible participants I approached to invite to participate in the study had already given birth by time we met. I played no role in their care or childbirth experiences. None of the participants had met me prior to giving birth.

During the first meeting I introduced myself by my first name and stated the purpose of my visit, namely my interest in uncovering young mothers' experiences when giving birth. I endeavoured to make the participants feel at ease by first asking them if they were willing to listen to the details of the research study. If they were, I would give an outline of the research and what their participation would entail. In order to create rapport with them, I would then start talking about their babies and the chosen names or the gender of their babies. The girls were mostly in shared rooms with other postnatal women, so I kept my voice down and closed the curtains for privacy when I spoke to them. Only one of the six called me by my first name; all the others either refrained from using any names or titles, or called

me 'Sister'<sup>22</sup>. It seemed difficult for them to address me by my first name. I had informed them that I was a midwife working in labour ward and left it up to them to address me in whatever way they felt comfortable. During the conversations I attempted to meet them at their level by using easy and understandable language and removing any nursing-distinguishing devices<sup>23</sup> to avoid making them feel intimidated or cautious to speak about the nursing staff that cared for them.

All the conversations were held with two chairs facing and no other barrier between me and the participant. If the participant seemed intimidated by the audio-recorder, I moved it out of her sight to avoid distracting her.

#### **5.4 INFORMATION UNRAVELLING**

I used the seven-step phenomenological analysis method as described by Colaizzi (Colaizzi, 1978).

1. I read through all nine conversations (six initial conversations and three follow-up conversations) over and over again until I knew each participant's story by heart.
2. I then studied each individual conversation. I searched for significant statements that each participant made and wrote them down; each conversation on a separate page.

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<sup>22</sup> In the South African context, professional nurses and midwives working in hospitals are addressed as 'Sister', followed by their surnames. All the lower nursing ranks are addressed as 'Nurse'.

<sup>23</sup> In South Africa, professional nurses wear maroon epaulettes on their shoulders with different coloured bars to indicate in which nursing disciplines they are qualified. These epaulettes distinguish professional nurses from staff nurses who wear white epaulettes, and nursing auxiliaries who do not wear any epaulettes.

3. For each statement I had written down, I formulated a meaning, for example when a participant reported that she “*couldn’t take the contractions anymore*”, the meaning created was ‘painful’.
4. The formulated meanings were divided into three clusters of themes, with sub-themes, according to a Husserlian framework. (Refer to sections 5.6 and 5.7.) Meaningful phenomenological terms from Husserl’s approach guided the grouping of the themes. The three terms were *essences, intentionality and consciousness*, and *life-world*; themes were created in accordance with these terms.
5. The three clusters of themes and the sub-themes were organised into one exhaustive description of the participants’ experiences.
6. The exhaustive description was summarised into a conclusive and validated statement to provide the reader with the clearest description of adolescent mothers’ childbirth experiences.
7. The validation of the interpretation of the study was done when I took the summarised results and exhaustive description back to the participants and reviewed my findings and themes with them.

## **5.5 EXHAUSTIVE DESCRIPTION**

The exhaustive description is divided into four sections identified as significant time periods for the adolescents. The period before labour refers to their preparation for childbirth and not to their experiences of pregnancy per se. The childbirth event is divided into labour, the birth and the postpartum period.

### **5.5.1 Before Labour**

The participants all felt apprehensive about the forthcoming labour process, the birth and professional treatment. One of the participants reported being shouted at and embarrassed in front of other patients during her antenatal visits at the clinic, and this made her fearful of what was going to happen during labour. Although all of them reported uncertainty about childbirth and associated events, none of them had attended antenatal education classes or reported reading up on the subject to prepare themselves. Hence the intensity of labour contractions and the duration of labour caught them by surprise.

### **5.5.2 During Labour**

During labour, girls of middle adolescent age have various perceptions about themselves, about labour and birth and the people involved during these events. They experienced the following feelings during labour: i) they were scared of what was happening to them and scared that they might be dying; ii) they were concerned about the baby's well-being during labour; iii) they were scared that they would not know how or not be able to push the baby when the time came; iv) they experienced frustration and anger towards some of the nursing staff for being rude; v) they felt ignored by the nurses who did not answer their questions; and vi) they were unsure of what was going on and what was expected of them.

The fear of discrimination and victimisation was very real to them. They expected bad treatment such as having people "*on top of them*" (Unathi) during the birth process and being shouted at by the nursing staff, for that was what they were accustomed to during their pregnancies at the antenatal clinics. Some girls mentioned that they were treated differently to the other



mothers; they did not know why they were treated badly. Some experienced that nurses were rude during labour and felt sad about and hurt by it; they expressed feeling 'useless' and 'hurt' and 'unimportant'. Most of the girls mentioned unfriendly nurses, but friendly and helpful midwives; only two reported an overall positive experience.

During labour and birth, the presence of a birth companion was highly valued and deemed extremely important to being able to cope with the pain. All the girls preferred their mothers to be with them during this time. Whether they were in relationships with the babies' fathers or not, they wanted their mothers to support them and to help them relax.

They needed to hear that everything was going well with the birth and that the baby was still all right. They wanted certain procedures performed during labour and birth explained to them in order to understand why they were necessary. They also wanted to have a say with regard to the procedures that were performed on or around them. This included augmentation and induction of labour, pain relief options, episiotomies, breaking their water (that is, artificial rupture of membranes) and handling their babies.

### **5.5.3 During the Birth**

During the second stage of labour, when they gave birth, the adolescent girls expressed a need for a great deal of guidance and instructions from the nurses on how to push. They were concerned about their ability to push and wanted the nurses to tell them exactly what to do and whether they were pushing correctly. They wanted to be encouraged to push and to know that they were doing well. They felt discouraged by and frustrated at being told that they were not pushing correctly, yet nobody told them how to do it the

right way. They felt upset when shouted at during the birth, but felt good and motivated when the nurses spoke to them in a respectful manner and told them when to relax and when to push.

#### **5.5.4 After the Birth**

All the girls expressed feelings of happiness and relief after the babies have been born. They were excited and started to feel like mothers. Generally their stay in the post-natal wards was positive, with the exception of one girl who experienced a humiliating event in the post-natal ward. None of the girls recalled concerns immediately after the birth; they were just happy that the baby was healthy and that the contractions were gone.

### **5.6 THEMES USING HUSSERLIAN FRAMEWORK**

Three essential themes with sub-themes were identified. The themes are presented according to three Husserlian concepts namely *essences*, *intentionality* and *consciousness* and *life-world*. The sub-themes and sub-categories are further expanded in section 5.8

#### **5.6.1 Essences**

The Husserlian concept of essences refers to the unchanging characteristics of a certain phenomenon which makes that phenomenon what it is (Jennings, 1986). Following Colaizzi's steps and forming meaningful clusters of themes, the essence of adolescent childbirth was identified as unpreparedness (essential theme one). The participants were not prepared for the challenges and reality of childbirth; their unpreparedness was categorised into two sections: (i) ignorance about the imminent labour and birth; and (ii) an unanimous feeling of incomplete physical and emotional development to

withstand the birth process. The essence of their childbirth experiences is therefore presented as unpreparedness from physical and emotional perspectives.

### **5.6.2 Intentionality and Consciousness**

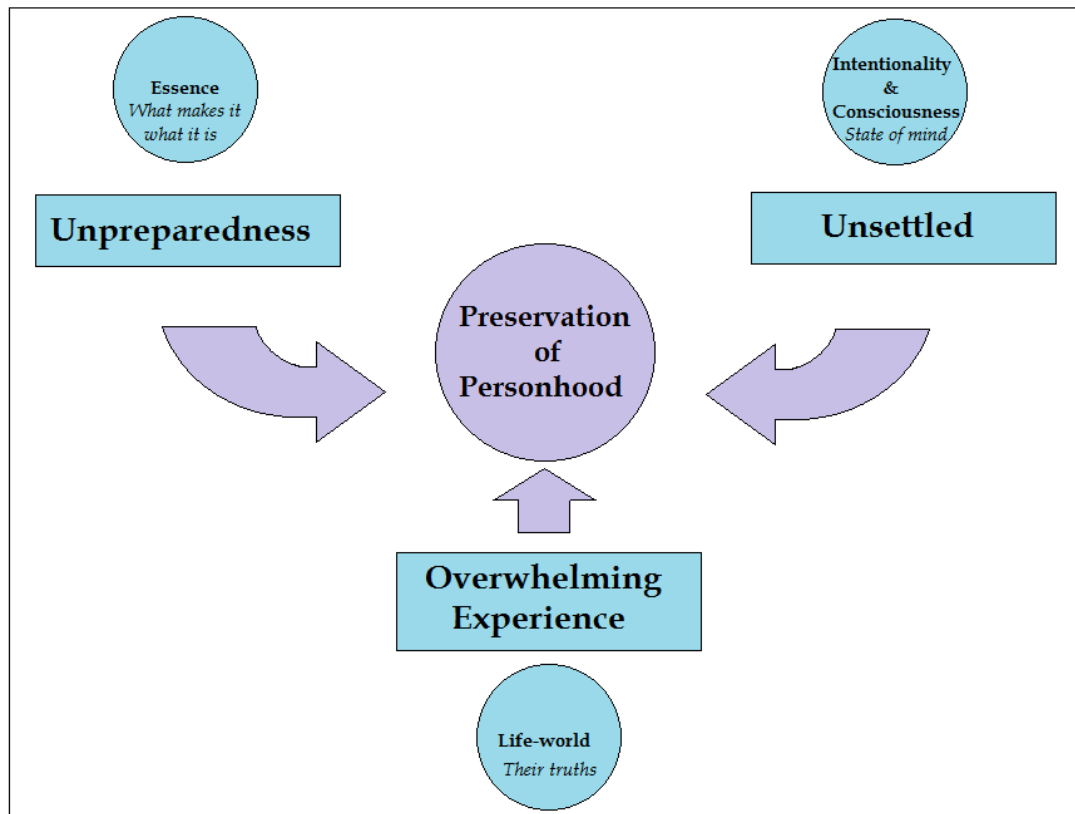
Intentionality refers to the awareness of ourselves, other people and our own thoughts, beliefs and fears. Consciousness is always intentional and refers to a person's state of mind (Siewert, 2006). The participants' general state of mind was affected by their own thoughts and fears regarding the labour process and birth, and was a state of feeling unsettled (essential theme two). Their unpreparedness predisposed them to the unsettled state of mind they found themselves in, since their uncertainties about the labour and birth process left them feeling anxious and fearful. The essential theme of an unsettled state of mind was divided into three categories with sub-categories: (i) a fearful state of mind; (ii) a submissive state of mind; and (iii) needs expressed by the participants to cope with their unsettledness.

### **5.6.3 Life-world**

Husserl's life-world describes a person's subjective experience of the world as we know it, meaning that every person's reality is his own truth (Smith, 2013). In order for the researcher to discover the life-world of participants, it is necessary to remove his/her own personal truth about the phenomenon and to focus on the participant's truth. The things in the world, as people experience them, form part of their life-worlds, their experienced sensory inputs, their perceptions of ethical values of right and wrong and their perceptions of other people (Chad, 2012).

The life-world of the participants was identified as an overwhelming experience (essential theme three) with different aspects of 'overwhelmedness' defined as intra- and interpersonal experiences. The participants' intrapersonal experiences were divided into two sub-categories: (i) overwhelmed by pain; and (ii) overwhelmed by emotions. Their interpersonal experiences were divided into (i) experiencing dehumanising treatment by the nursing staff, but also (ii) experiencing encouragement and kindness from the nursing staff. Each participant's physical experience and sensation of pain is unique, but all of them reported pain as part of their life-worlds, which formed a collective theme. Some of the participants experienced a more positive birth, and therefore an individual sub-category of encouragement and kindness was identified as part of their interpersonal experiences.

The three themes identified using the chosen Husserlian framework are reflected in figure 2. These three essential themes indicate how the overarching theme 'Preservation of Personhood' was developed.



**Figure 2: Themes identified using the Husserlian framework**

All three essential themes were embedded in the search and preservation of the participants' sense-of-self, their individualities and their self-worth; in other words, their personhoods. The participants' unpreparedness indicated a lessened sense of self, as they did not make the effort to prepare themselves for childbirth. Inevitably, their unpreparedness led to an unsettled state of mind, resulting in fear and anxiety during childbirth. The attempts to maintain their individualities were evident from the participants' expressions of certain individual needs in order to cope with labour and birth. The 'overwhelmedness' experienced by the participants was linked to the challenges they faced when their self-worth and humanity were disregarded. The presentation of the overarching theme follows in section 5.7.

## 5.7 OVERARCHING THEME - PRESERVATION OF PERSONHOOD

Described in many ways by different philosophers, personhood in simple terms refers to the person as an individual human being; philosophers are, however, still conflicted about the depth of individuality contained in the concept of personhood (Hahn, 2012).

Although the participants were divided about positive or negative birth experiences, one important theme was identified as the central idea of their entire childbirth experience: to preserve their personhood or sense-of-self. The participants' accounts describe experiences of intense emotions and a constant battle to preserve their sense-of-self and to not lose their individuality and humanity in their experiences as a result of the way they were treated. The most important aspects of childbirth were to be treated as human beings and to feel worthy of respect and care as a human being.

Farrah narrated how an assault on her personhood had left her feeling like someone not worthy or valued as a person:

*"Well it made me feel like somebody that's useless because of the way she treated me and ... it was like 'ruk en pluk' [push and shove] ... Like ... the way like- when I told her- just relax I need to ask – but she told me I must get on the bed, now that pain comes and it's very sore." Farrah*

During the conversation, Unathi described how she felt that the midwife cared about her, because she wanted to know how she was feeling after the birth. When I asked her how it made her feel that someone cared about her after the birth, her response was powerful:

*"Like ... I felt like a person again ..."* Unathi

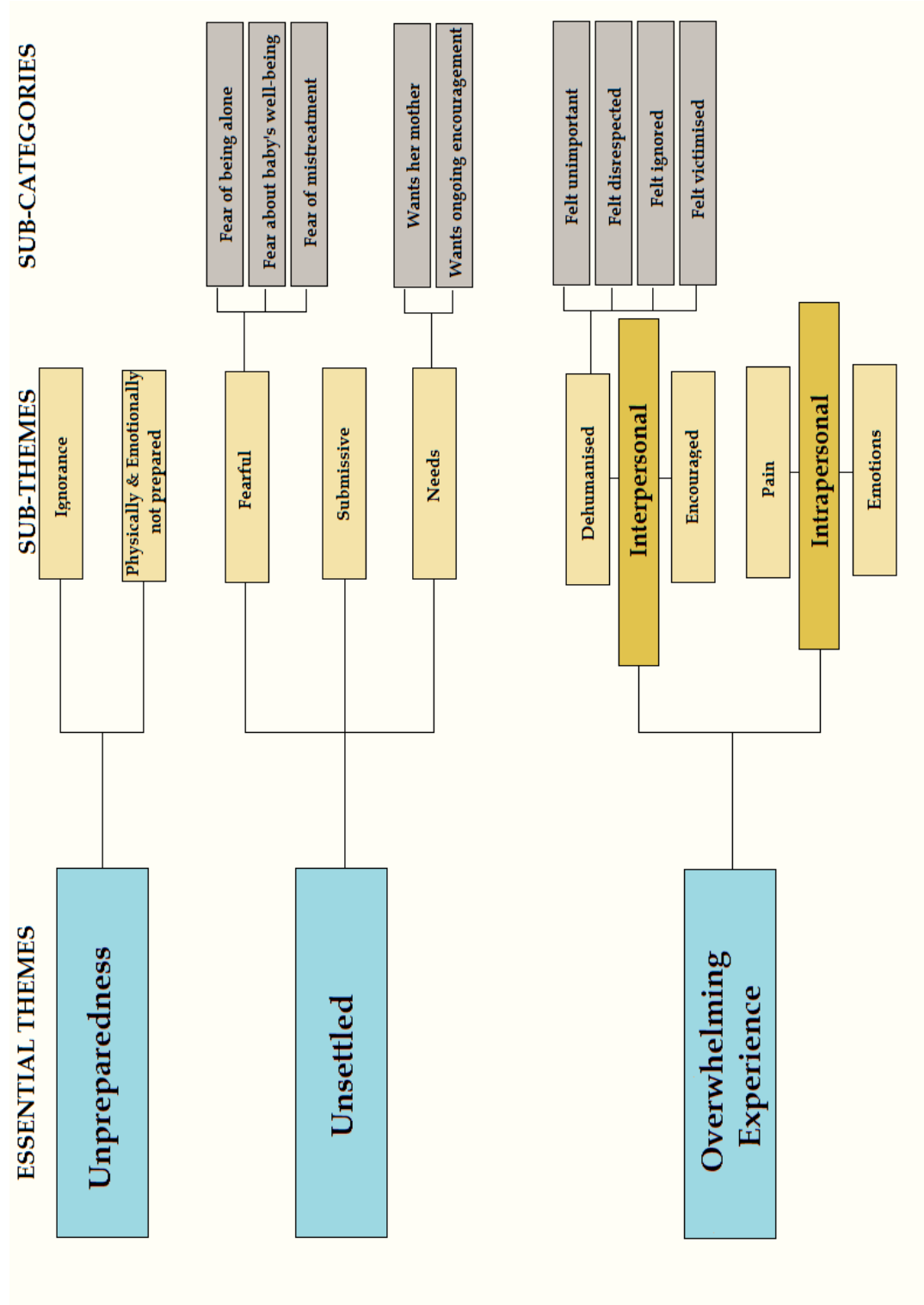
A labouring mother can intensely experience the simple act of enquiring about well-being as a sign of care, which can influence the way she views her experience. Whether the midwife had meant to ask if she was feeling 'okay' physically to get up and be transferred to the postnatal ward, or whether she had meant to ask if she was feeling 'okay' emotionally, for instance happy or sad, Unathi felt cared for. Her positive birth experience was influenced mainly by her positive interpersonal relationship with her caregiver, even though she had no support person with her during the birth.

The participants sought different coping mechanisms to survive the physical, emotional and psychological challenges that childbirth posed and to still uphold their personhood. Although their individual experiences were vastly different from one participant to the other, similar challenges and coping mechanisms were identified across all their unique experiences. Based on these commonalities, the essential themes, sub-themes and sub-categories were identified and described in detail in section 5.8.

## **5.8 EXPANSION OF THEMES AND SUB-THEMES**

In this section, the process and identification of the essential themes are expanded to include detailed descriptions of the development of sub-themes and subsequent sub-categories. The three identified essential themes are presented in figure 3 according to the Husserlian framework. Extracts from the participants' conversations are incorporated throughout this section to substantiate the identified themes and sub-themes.

Figure 3: Presentation of Essential Themes and Sub-themes





The discussion of the first essential theme (unpreparedness) is presented in section 5.8.1, followed by the discussion of the second essential theme (unsettledness) in section 5.8.2. The third essential theme (overwhelming experience) is presented in section 5.8.3.

### **5.8.1 Essential Theme One: Unpreparedness**

Even though the participants in this study were all of a lower social-economic status and it seemed plausible that they did not have access to the media or other educational facilities to prepare for childbirth, the reality appeared to be different. From the participants' different accounts of their uncertainties about childbirth, their lack of knowledge may be attributed to their denial during pregnancy and little motivation to accept the reality of their pregnancies.

A common feeling among the participants was that of experiencing completely unexpected happenings. The labour and birth were nothing like they had imagined and every participant experienced it as much harder than they thought it would be:

*"I never thought that ... bringing someone to earth would be so hard and ... it's just stressful. And then after that I realised; this ... is really a hard thing." Unathi*

Unathi's extract represents the unanimous feeling among the participants regarding their childbirth experiences. Their ignorance was obvious in their accounts of confusion and uncertainty about the process happening in their bodies. Their physical and emotional unpreparedness was evident from their expressed doubts about and fears of their abilities to cope with childbirth.

The two identified sub-themes of ignorance and emotional and physical unpreparedness are discussed below.

#### 5.8.1.1 Ignorance

From the conversations with the participants it became evident that they went into labour and did not know what was happening to them or why it was happening to them. This potentially ensued from their lack of knowledge as well as their physical and emotional unpreparedness for the birth. They were surprised by the intensity of the labour contractions and seemed to not be adequately equipped with coping mechanisms to handle the pain:

*“Because for me as a teenager, I didn’t know anything so ... yeah it’s my first time and I didn’t expect this ... [the painful contractions].” Aquila*

All the participants reported uncertainty regarding the labour process, the birth and certain expectations:

*“I felt very shy because I am still young ... and it’s my first time. I have no clue what’s going on around me, I also came for the first time. I thought – can I ... [tries to explain with her hands] if I can cooperate because I don’t know this ... afterwards it felt all right.” Cindy*

In my study, the participants explained that they did not know what to expect in labour and that most of the time they did not know what was happening with them or around them.

*Because ... I asked her... uhm ... some questions like ... how is she going to take the baby out and why is the pain so sore?” Stacey*

During this part of the conversation, Stacey was sitting with her hands clasped together between her knees, her body language tight and anxious, even though her voice was clear and not filled with emotion. In this regard, Stacey's body language revealed more about her anxiety and fear than her narrative did.

#### 5.8.1.2 Physically and emotionally unprepared

Many of the participants referred to their age and immature physical developmental stage as reasons for finding labour so difficult, and more than one expressed the thought that her body was not ready for childbirth:

*"It is not nice because your – your body isn't yet fully developed like an adult's. And it's sore too" [When asked to elaborate more] ... Your inside bones are also not yet strong enough like someone who's fully developed ... that's what I mean."* Mavis

*"It's hard for me. For teenagers like me. So hard. And ... painful. Yhew ... it's not nice to be there. Maybe it's my age, I'm young."* Aquila

These narratives illustrate that the participants were aware of the fact that physically they were not fully developed when they fell pregnant. The participants expressed doubts about labour and their capability of coping with labour and 'pushing their babies out':

*"I thought I couldn't push, I shouted at the sister that I couldn't anymore, the pains are too strong."* Cindy

*"[What it was like to have a baby as a teenager] because you are still closed as a teenager, you are not yet properly open." Farrah*

Other participants felt that adolescents were emotionally too young to go through labour and that they did not think it is good for them to have babies until they are older:

*"I don't even know what to say but, I don't think it's good for us, for teenagers ... like me, teenagers like me ... it's not nice being in labour ... I can say. [Pause]. Not nice at all." Aquila*

*"I will tell her [another adolescent mother-to-be] that it's very sore. She mustn't ... have babies because it is very painful, she should wait until it is her time. Until she's eighteen or nineteen ... or twenty-one. She mustn't make babies now." Mavis*

During the conversations, the adolescents reflected on their experiences and were honest about their ages and being young mothers. The participants were informed that the research was about adolescent mothers and childbirth; they themselves, however, without prompting, referred to their ages:

*"It's different because we as - me as a teenager, it was too hard for me. I can say it's better big, uhm ... I mean adults like thirty year old, twenty-five year old but not teenagers like me. It was so difficult for me and ... huh-uh ... very painful for me. It's not good." Aquila*

## 5.8.2 Essential Theme Two: Unsettled

The participants' state of mind during childbirth was that of feeling unsettled. It was an unfamiliar environment with unfamiliar faces and an unknown journey from which there was no turning back. The participants expressed a heightened state of fear during childbirth, stemming from the fear of being alone, concern for their babies' well-being and a fear of being mistreated by the nursing staff. The participants mentioned certain needs they had wanted to be addressed throughout childbirth, such as a birth companion and encouragement. During the birth, all the participants resorted to a submissive and obedient frame of mind towards the attending midwives, believing that if one just followed the instructions of the midwife<sup>24</sup>, all would be well. The sub-themes are presented in more detail below.

### 5.8.2.1 Fearful

All the participants experienced a heightened sense of fear of the different aspects of childbirth. The feared being left alone during labour, they were concerned for their babies' well-being and they feared mistreatment from the nursing staff.

#### 5.8.2.1.1 Fear of being alone

The participants voiced their fear of being left alone during labour and birth and how they needed someone with them in labour. The support person's presence meant being there or rubbing their backs during the contractions.

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<sup>24</sup> In South African hospitals, nursing auxiliaries work together with midwives in the maternity wards. Participants often referred to nurses when they were in fact talking about the midwives. These referrals are clarified in the text. When it was not clear in certain instances, the text refers to nursing staff as an encompassing term for nurses and midwives.

*"Your mother and your daddy ... or your boyfriend ... and so, must be there then you'll feel all right cause if you you're going to feel alone and you are alone then you're going to feel lonely. [Pause] And ... you're going to think nobody's supporting you." Mavis*

*"Well ... uh ... I get pain; you want someone to be there for you, to rub your back and so. Like they didn't even want my mother to come in, to rub my back or anything." Farrah*

Stacey reflected on the time when she was transferred to the postnatal ward with her baby and stayed in a single room by herself. Although she did not articulate her need to not be alone, her reference to this particular incident illustrated clearly that this was not what she had wanted:

*"They just left me there in the room ... all by myself." Stacey*

Stacey had a challenging and emotional experience giving birth to her baby, and all of a sudden she was alone. She was all by herself with this new baby, with no nurse or midwife around to ask for help or anything. This narrative illustrated that even though the baby is born and both mother and baby are healthy, during the immediate postpartum period, an adolescent also does not want to be left alone. Without voicing her need, Stacey indicated that she had needed a nurse around or possibly another patient to share her room with - as long as she was not by herself.

#### 5.8.2.1.2 Fear about baby's well-being

The responsibility of answering questions and addressing concerns usually falls on the midwife who looks after the labouring woman, since she, from all the health professionals, spends the most time with the woman in labour.

One concern raised by the participants was the health and well-being of their babies during labour, and specifically about the birth:

*"I felt scared ... worried if the baby's going to be healthy if he was delivered ... some of the doctors made me feel ... like I didn't want to be there. Because they didn't help me ... the way I wanted them to help me. They gave me attitudes and that if I asked them a ... uhm ... questions and they didn't like it actually. " Stacey*

Despite Stacey's trepidation regarding her baby's health, her body language did not reflect the same emotions that she conveyed. Her voice became louder with some underlying anger, yet her hands were still clasped between her knees; her non-verbal language not reflecting the anger she felt.

In contrast, Unathi's hands supported her narrative with gestures and her voice became slightly softer, as if she was afraid to voice her fears out loud:

*"Wow ... during labour, I was scared that ... what if I take out the head then ... I stop pushing, then ... I squeeze her neck and stuff. That was the only thing I was worried about, squeezing her neck. What if I squeeze the neck and so? Then, when I was about to start pushing, she [the midwife] was like 'relax and push' and so." Unathi*

Unathi felt anxious about her baby's well-being when she gave birth. It is evident from her narrative that the midwife's words had a calming effect on her during this moment of intense fear for her baby's life. She had delivered a healthy baby soon after to her own relief:

*"[How did she feel when the baby was born] Excited ... because I made it. Some people don't make it, they say when they baby is out and then the*

*baby gets tired and the baby dies and they start crying and all that stuff. Then I made it, the baby was there, the baby cried when she came out and then she wasn't tired and stuff. I was so ... it was exciting."* Unathi

The lack of adequate communication with the health professionals was an obstacle for some of the adolescents in labour. They had many questions that stayed unanswered, which left them feeling uncertain and scared:

[What would have been calming] *"If the sisters ... or someone else could just talk to me. [Pause] That could've told me when to breathe in and out and tell me that I shouldn't worry, everything will be all right."* Cindy

#### 5.8.2.1.3 Fear of mistreatment by the nursing staff

Stemming from different experiences, either antenatally or at different hospitals, the participants expressed a fear that they would be mistreated by the nursing staff, especially be shouted at during birth. Unathi's negative experience during her antenatal visits made her feel apprehensive towards the treatment she would receive in the hospital:

*"I thought when I come to hospital it's going to be worse! And even when ... if I'm giving birth, I thought they're going to be shouting and stuff. And I didn't expect one person when trying to give birth, I expected like three people on top of me ... Like ... holding me back."* Unathi

Farrah spoke a lot about the care she received and was visibly upset during the conversation about the way she was treated. During the interview she said that she had expected the midwife who delivered her baby to shout at her and treat her 'horribly':



*“Because the way – the nurse when I came in. When she now checked how far am I, how many centimetres am I. The way she was with me, it was like ... and I thought maybe all nurses are going to be so.” Farrah*

Farrah’s drawing (figure 4) consisted of two parts; the first part she drew was based on her experience of the nursing staff’s behaviour towards her at the MOU, which made her anxious about coming to the hospital:

*“Uh ... okay it think I cried also because of how the nurses there under by the MOU treated me ... in that block [drawing below].” Farrah*



**Figure 4: One part of Farrah’s drawing – of her experience at the MOU**

#### 5.8.2.2 Submissive

It was a common feeling among all the participants that as long as one followed the midwives’ instructions and did as they were told, the birth would be safe and the baby would be unscathed. The participants did not express the desire to give birth in any other manner or position other than what they were told to by the midwives; they trusted the midwives to guide them correctly:

*"And the nurse that helped me ... deliver, she was also nice. She wasn't like rude. She was there like, to guide me on the right way and I went after what she said and then I had a safe delivery." Farrah*

*"I will just say ... don't' scream. Breathe in and out and don't worry about the pain – it will go away again. If you – after the child is born then everything will be all right again. Just calm down, work together with the sisters and then the sister will work together with you." Cindy*

It was evident from the conversations that the participants wanted guidance during childbirth and felt that they had safe deliveries because they had followed the midwife's orders obediently and because they had cooperated:

*"Because if you don't do what they tell you to do then you can stay there forever and you can't give birth and the baby can't come out. It can take long for the baby to come out. But you just need to follow their instructions." Aquila*

Stacey felt abandoned and neglected during the birth because of the lack of guidance from the midwife who attended the birth. Even though she wanted clear instructions from the midwife, she also felt that she would not have been able to go through the birth process if it were not for her mother as support person.

Unathi, on the other hand, had a positive birth experience, although she had undergone procedures that she did not understand but tolerated, and she had obeyed the instructions when she was told that is 'the best for the baby'.

*"Because they were ... they were holding me. And then they told me to relax, all the time the- those belts were around me that was so tight ... I've told them it*

*was tight* [moving her hands over her abdomen and sides where these belts were strapped during labour; frowning while she spoke], *they told me it was for the best, so I had to relax because they think it was for the best. And I had to hold myself, even though it's tight - the ... I had to hold myself.*"

Unathi

When she was asked how it had made her feel to have to 'hold herself' and tolerate the procedure<sup>25</sup>:

*"Just because they said it was for the best, so I thought it [shrugs her shoulders] - it is sore but then I'm going to try and relax even though I don't like these belts, but they ... if it's for the baby, I'm going to survive."*

Unathi

#### 5.8.2.3 Needs expressed by the participants to cope with their unsettledness

An unsettled state of mind was experienced by the participants and in order to cope with this they described certain needs they had during childbirth. They expressed the need for their mothers as birth companions and to receive ongoing encouragement from the nursing staff throughout childbirth.

##### 5.8.2.3.1 Wants her mother with her during labour and birth

All six the participants had their mothers with them as support persons at some point during childbirth. Even though some of the participants were still in relationships with the fathers of the babies, the fathers did not feature as important factors during childbirth. It was important to all of the participants

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<sup>25</sup> What Unathi described as being "*too tight*" were the belts that are used in maternity settings to strap the leads to her abdomen from the cardiotocograph (CTG) machine that traces the fetal heartbeat and the mother's contractions.

to have their mothers with them. Those who had laboured alone expressed that they would have wanted their mothers with them:

“[What had helped her cope with labour and birth] *My mommy. She was the only one that could make it easy ... for me.* [When asked why she said that] ... *Because she's more close to me and I couldn't let anyone near-get near to me because then I get mad, so –so was the pain.* [Pausing for a moment to think] *So she was the only one that could be there for me.*” Stacey

“[Why she said she needed her mother] *Because my mom will help me calm down.*” Cindy

“Well ... *the bond with me and my mommy is ... we're like best friends, I tell her everything and ... like ... how can I now say ... if she's there, then it's like ... she'll guide me in the right direction, she'll tell me 'Don't do that' ... uhm ... 'Do this way' ... uhm ... that's how it help me.*” Farrah

Three of the participants had their mothers with them at the hospitals, but due to a lack of communication, their mothers were left outside while they gave birth, because they were not aware of the fact that they were allowed in with their daughters. The participants spoke about this:

“*Because it makes sore like ... they didn't like ... everybody's pain is different, maybe my pain was worse than their pain and I needed my mommy there by my side* [standing during the conversation and now pacing around and fiddling with some papers on the table].” Farrah

*"[What she had wanted the nurses to do differently]. I think ... having my mom there with me I think ... [Why] It would mean everything ... cause ... she was the one who supported me all the way."* Unathi

Participants also recounted this when describing how their mothers' presence during labour helped them to cope with the contractions:

*" ... And she told me sweet words and they just made me feel better ... "*  
Aquila

*"What was bad for was that they told me ... I'm not pushing. And what was good for me was that my mom was there with me."* Mavis

Only one of the girls expressed that, besides her mother, she also would have liked for her boyfriend to have been there with her during labour:

*"Yes my boyfriend [giggles]. My boyfriend was late ... I think he also could have helped, he would have supported me."* Cindy

One participant described her relationship with her mother and why it was so important for her to have her mother by her side:

*"She meant everything. Because ... yhew ... my mom ... she was with me every step of the way. And then ... when I was - when I went to the labour ward, she ... she looked at me, and smiled. And I was wondering why she was smiling. And then, she said [speaking a Xhosa sentence and then translating herself] 'it's time now'. And I was like, time for what? And then she was like 'For you'. Time for me? I didn't get it at the time, then after the baby was born and I called her in, she was like 'This is what I meant' [Xhosa sentence with translation after] 'It's time for you, to be a mom' [And after*

another moment, deep in thought] *Yeah, she's ... yeah ... I don't know, she's my angel actually.*" Unathi

#### 5.8.2.3.2 Wants ongoing encouragement and reassurance

The need for emotional support emerged time and again during the conversations with the participants. Besides wanting their mothers with them as support persons, they expressed the need to be reassured during labour that they are doing well and to be encouraged to keep going. One participant explained how she wanted to be encouraged by the midwives:

*"No ... but she [the midwife] tried. She could say I must ... I must be strong. That's what she could say ... I must just be strong [speaks loudly]."*  
Aquila

This anecdote indicates that the participant needed the midwife to encourage her during labour, in order to help her to deal with the contractions and to get through them and "be strong". The following participant felt that she received no help whatsoever from the midwife or nurses during the birth:

*"They didn't help me! [almost shouting]. My mother helped me."* Mavis

The midwives' lack of encouragement was also illustrated by the following narrative. Stacey was asked what she had wanted from the midwives during her labour:

*"To help me ... a lot. Because I was still young. So ... and to uhm ... speak to me, tell me what to do. Like uhm, breathe, how you must breathe and when you must push. But nothing like that happened. They just stood there; my mommy had to tell me everything."* Stacey.

Cindy remembered that it had helped her to focus and encouraged her when the midwife told her that she would help her when she felt that she was not coping anymore:

*"Then the sister said 'don't worry about the pain, I will help you. If we are – if you cooperate then I will help you to get this over and done with.'" Cindy*

Although this might seem like a threat to cooperate, the participant's tone of voice during the conversation was rather soft and encouraging when she quoted the sister's words. Her non-verbal behaviour was open and she was leaning forward when she told her story, creating the sense that the midwife explained to her how she could help her rather than threatening her to cooperate or else ...

### **5.8.3 Essential Theme Three: Overwhelming Experience**

Irrespective of the participants' accounts of positive or negative birth experiences, they all described their life-world during childbirth as an overwhelming experience. The participants' 'overwhelmedness' emanated from their own physical experiences as well as their interaction with the health professionals. Therefore the sub-themes identified were grouped into the participants' intra- and interpersonal experiences and are described according to sub-categories below.

#### **5.8.3.1 Intrapersonal experiences**

Intrapersonal is defined as 'existing within the mind' (Oxford University Press, 2015f:1). Two sub-themes emerged during the conversations as the deeply intrapersonal experiences of the participants. These identified sub-themes were the overwhelming experiences of physical pain and emotional

turmoil. The participants were all overwhelmed by the level of pain they experienced and all of them recounted having a hard time to deal with the contractions during labour. This overlapped with the storm of emotions they experienced during the birth - from feeling fearful to angry and excited. Some of the participants even experienced all of these emotions within a short time span.

#### 5.8.3.1.1 Overwhelmed by pain

The participants expressed their experiences of childbirth in different ways, but it seems as if they were all overwhelmed by the level of pain that they had experienced. Pain was described as one of the negative memories they had about their childbirth experiences:

*"It was bad and it was so painful that ... I don't think I'll forget this day. And I don't even think I'll try to do it again [shaking her head] ..."*  
Aquila.

*"It was very difficult because the pains were so sore ... you hurt a lot [closing her eyes]."* Cindy

All the participants wanted pain relief, since they felt that it was too much to bear. However, only one out of all the participants received pain relief in the form of an injection when she could no longer cope with labour:

*"It was very sore, I couldn't take it anymore ..."* Mavis.

During the conversations, it also became evident that the intensity of the labour contractions caught the participants by surprise. One of the



participants experienced an intense sense of dread and described her labour as follows:

*"I felt like I was going to die! That's all you feel, like you're going to die, you're not going to make it, you just telling yourself 'I'm not going to make it, I'm not going to make it, I know I'm not going to make it.'" Farrah*

Farrah explicitly referred to her pain over and over as a negative experience:

*"The bad memories that I was going to - that I felt like I was going to die [speaks loudly]." Farrah*

It is clear that the participants associated negative memories of their childbirth with the amount of pain they had experienced. Aquila's drawing (figure 5) pictured a deep sense of sadness in herself, standing and holding her abdomen with tears running down her face. She stared at the picture on my lap when she spoke about her pain, with intense sadness written all over her face:

*"Yeah this picture comes too clear in my mind [the picture she drew] and I can't forget this day. It was s-o-o-o very sore and I don't think I'll do it again." Aquila*



**Figure 5: Aquila's drawing**

#### 5.8.3.1.2 Overwhelmed by emotions

Over the course of only a few hours, these participants experienced a turmoil of emotions during each phase of labour, birth and the immediate postpartum period. Each participant had experienced childbirth in her own unique way, with her own unique feelings about the event. Nevertheless, they had all faced challenges during childbirth and expressed certain emotions they had felt during this time. The participants narrated the following emotions that they experienced during childbirth:

##### *Frustration*

*"... Cause I was frustrated with the people. I got frustrated cause they didn't know what to do; they were just standing there every time in front of me. Then they walked, then they leave me there." Stacey*

### *Embarrassment*

*"I was a bit shy because I am very young." Cindy*

### *Irritation*

*"She [advice for future adolescent mothers] must just uh ... she must relax. Like not try to get the nurses ... to irritate her. Cause at that moment everything irritates you." Farrah*

### *Scared*

*"I felt scared ... worried if the baby's going to be healthy." Stacey*

### *Anger*

*"They must ... they say I have to push, push, I'm not pushing – they must speak a little better to me!" Mavis*

### *Sadness*

*"Ah ... I felt sad because [laughs] ... that person, she – they were – they already have children and she knows how painful it is but she ... still, she doesn't feel that, she didn't feel shame for me. That's why it makes me sad. But I can say one of them at least tried, they knew how it feels. How it pains."*

*Aquila*

## Relief

*"I felt relieved. Yeah ... Actually no one was shouting at me. Even though I thought someone was going to shout at me. I had that feeling, someone's going to shout at me but then that didn't happen. So I was relieved." Unathi*

## Excitement

*"[After the baby was born] I was ... excited." Unathi*

### 5.8.3.2 Interpersonal experiences

Interpersonal refers to the concept of 'relating to relationships or communication between people' (Oxford University Press, 2015g:1). The participants' interpersonal experiences were divided into two opposites: experiences of dehumanising treatment and experiences of encouragement and kind treatment from the nursing staff. These experiences were not solely negative or positive accounts, but rather depended on one-on-one interactions with the health care professionals during labour and birth. For instance, one participant's narrative conveyed a harsh nurse when she was admitted, but a helpful and friendly midwife who assisted her during the birth.

#### 5.8.3.2.1 Dehumanised

Most of the participants experienced treatment at the health care facilities that made them feel 'useless' and not respected as human beings. They expressed how certain nursing behaviours left them feeling unimportant, disrespected, ignored and victimised during childbirth.

#### 5.8.3.2.1.1 Felt unimportant

The participants reported feelings of unimportance during the conversations and explained how this kind of behaviour towards them made them feel. During the conversation, Farrah felt upset about the way she was treated when she arrived at the hospital:

*“All the sisters was okay, but me, it wasn’t so long before I went into labour, but then there was this one nurse that was very cheeky [frowning while speaking] ... probably because I was underage or so ... but yes, but okay everything went well ... and that’s that.” Farrah*

Although Unathi reported a more positive birth experience, she voiced her apprehension a couple of times about being treated badly or being shouted at. Her apprehension sprouted from her experience during her antenatal visits, where one of the sisters had shouted at her in front of all the other patients for being late for her appointment. Hence it was her worst fear to be shouted at again in labour because of the way it made her feel at the clinic. She described it as follows:

*“It was ... when I was six months I think. Yeah. It was ... I actually, I got there at five past eight, I was supposed to be there at eight o’clock. And then, when I got there the sister was like, ‘This is not your time, blah blah blah’ and I was like, when I looked around people were looking at me. And I was like ‘Sorry!’ all the time [talks very loud], every time she shouted ...” Unathi*

Unathi became visibly upset during this part of the conversation - as if she was reliving the moment at the clinic. She was shaking her head and used her hands while she spoke; it was clear that this incident had a great emotional impact on her:

*"Yhew I feel ... I just feel useless. Why is she going to shout at me? Especially in - in between people. Like, if we're a crowd ... then you shout at me. Everyone's going to turn and look at me and then, all those words are going to hurt me ..."* Unathi

Stacey reported humiliating treatment in the postnatal ward when she was bleeding after the birth and the blood soiled the floor. Stacey narrated how the nurse made her clean up by herself:

*"And I came on top where you sleep ... and the ... I bled [stutters slightly] I bled through ... and then I asked that lady can't she help me? And she told me no she can't; I must wipe it up myself. [Silence] And I had to go on my knees to wipe everything up while I was still sore."* Stacey

*"[How it made her feel] I didn't feel it. I felt almost like I would, I didn't – I wouldn't want her to pick it up but I was thinking if the people come in and the blood's laying there, what didn't they think of me? So I had to run to the toilet while I was bleeding the blood, so I had to wipe up all right through the aisle with my facecloth. She wouldn't even bring me something to wipe it up with."* Stacey

All three participants reported that they felt humiliated because of the way they were treated. Two of them used the word 'useless' to describe how unworthy they felt of being treated in a dignified and humane manner. They were stripped of human worth and made to feel like nothing. They felt that they were not good enough to be looked after and not worthy enough to be cared for or to be treated respectfully.

Stacey was only aware of her feelings of embarrassment and humiliation; she was not even aware of the physical implications: that minimal blood loss

after childbirth is normal and lasts for a few days up to a few weeks. However, immediately after birth, some women experience severe blood loss, which is classified as postpartum haemorrhage<sup>26</sup>, constituting an obstetric emergency. In Stacey's situation, she was bleeding onto the floor and the possibility of postpartum haemorrhage was present. The participants' narratives painted a clear picture of the lack of empathy and care they received from the nursing staff during childbirth:

*"They must just understand you know, they must just understand that this person is in pain, so if I do 'that' I'll make her more sore, you know? The pains come strong you know, but then they must just understand ... "*  
Aquila

*"And then if I come to you and then I say 'When you said that, I didn't like it' you still shout at me! ... [softer] I'm just going to cry [If she is shouted at]." Unathi*

#### 5.8.3.2.1.2 Felt disrespected

Most of the participants shared their experiences of the disrespectful care they received during labour and how it had upset them to be treated this way:

*"Then I told her 'Just relax, let this pain first go away and then I will lift myself to the bed'. Then she was like 'Come! Klim opi kooi,kom!' [Come! Get on the bed, come on!] [loud] And that wasn't nice because my body is*

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<sup>26</sup> During birth a blood loss of more than 500 ml is associated with a drop in blood pressure and a rise in heart rate with a possible need for a blood transfusion (Cronjé, Cilliers & Pretorius, 2011). This complication of childbirth can lead to episodes of fainting and, more seriously, hypovolemic shock and death if the blood loss is severe.

*sore, like ... get tiring and she was just like 'Kom kom, klim op die kooi! [Come come, get on the bed].'" Farrah*

[I felt like] *"Like a lost case or something like that."* Farrah

*"Even though some of them was so rude but ... some of them tried. I can say that. [When asked how it made her feel] ... It upset me and it makes me sad."* Aquila

Although she was not too emotional during the conversation, Aquila did not look me in the eye during this part of the conversation; she was staring down at her baby who was lying in her lap and was fiddling with the blanket. Her body language seemed to convey that she did not want to think about this experience any longer than she had to, as it appeared to be too upsetting to think about again.

#### 5.8.3.2.1.3 Felt ignored

The participants narrated that they felt ignored during labour and not attended to when they had questions or asked for something. They had concerns and uncertainties about the process that needed answering, but felt that these were not addressed by the nursing staff:

*"Because ... uhm ... no like they [the nurses] won't take note of you and ... like, they didn't even bother ... it was like 'yeah you are going into labour and fine'. When I came there, I had to wait looong for help cause they was first helping people that had babies, they were first helping them before they helped us."* Farrah



*"It was almost like they [the nurses] didn't have time for me. But they were doing nothing, just walking down the aisles." Stacey*

*"Because ... I asked her [the midwife] ... uhm ... some questions like ... how is she going to take the baby out and why is the pain so sore and then she just looked at me and she walked away. And she went to that other room where they were delivering the other baby." Stacey*

Not all the participants were able to verbalise that they felt abandoned in such specific terms, but they did reveal these underlying feelings while talking about other things:

*"I ... uhm ... I don't think she [her mother] could do anything more to help me because ... the doctors couldn't even help me! [Laughs again]. Couldn't even help me to take the pains away so ... I don't think my mother would ... all she could do was- is just sit there and ... watch me." Aquila*

Aquila was asked whether there were things that she had wanted the nurses to do differently during labour. She mentioned pain relief repeatedly, but was under the impression that there was nothing to do about the contractions and that she had to suffer through them on her own:

*"I wanted them to take the pains away from me but they didn't. But I don't think it's possible ... possible to take the pains away. Because that's how it is ... that they can't." Aquila*

A woman in labour might be convinced that nothing will help ease her pain if she was told so or if no alternative was given to her for pain relief. Aquila was convinced that nothing could have relieved her pain, which suggests that she was probably never offered pain relief.

#### 5.8.3.2.1.4 Felt victimised

During the conversations with the participants, most of them spoke of being treated differently to other patients. Two of the participants angrily raised questions during the conversations about why they were treated differently to the other patients. The participants found it upsetting to be singled out and treated badly among the other patients when they had not done anything to antagonise the nursing staff aside from being there and being young:

*"Like ... it made me feel like ... like how can I now say, it's almost like ... she wasn't like, how can I now say ... like it was almost like ... 'You're a kid man!' "So ... I mean every patient should be treated the same. But when she went like- you know what also made me feel 'chunk' [unclear] - when she went to the other patients, she treated them nice but when she came to me then she was like shouting and ... so." Farrah*

When she was asked how she thought the nurses who looked after her could change their behaviour and do things differently, Aquila voiced feeling upset about the way she was treated compared to other patients:

*"I'll tell the others they must change ... they must think about the others. Because we are all the same ... you can't treat others so bad and others ... we are all the same, must treat - they must know how, you know, how to treat each other." Aquila*

Although Farrah reported that her midwife as very helpful and friendly, she spoke about the unfriendly manner in which she was received at the hospital initially and how it had upset her at the time:

*"Well I felt bad because why isn't she doing it to the other patients? Why to me only? But then when I delivered and my mommy was in the room by me then she was like nice to me because my mommy was there and the other nurse was there. Then I told my mommy in front of her 'Mommy, this is the nurse that was so rude.' So my mommy just looked at her like ... okay then ..."* Farrah

*"And I mean, she wasn't even rude to any of the other patients."* Farrah

And when she was asked how it made her feel, she replied:

*"Like ... why me alone?! Why not them?"* Farrah

It was important to the participants to be treated just like everybody else. The ones who were treated differently felt victimised mostly because of the fact that they were so young in relation to all the older mothers and not because they exhibited certain behaviour. They could not understand why they had to be treated differently and why they were not deserving of the care that the older mothers around them were receiving from the nurses.

#### 5.8.3.2.2 Encouragement and kindness

Only a few of the participants narrated that they had experienced respectful nursing care and felt very satisfied with the care they had received during childbirth. Cindy remembered her midwife and auxiliary nurses with gratitude, which was evident in her voice when she spoke of them:

*"They respect ... they respect me."* Cindy

Unathi had also experienced the nurses as caring and reported a very positive birth experience because of the care and compassion she had been shown during labour:

*"She was like 'relax' and I'm ... just do it." Unathi*

*"You delivered the baby, they [the midwives] just look at you and they're like 'No she's fine'. So even though, even if I don't ask her I can just see she's fine. They carry on with what they're doing and they get out of the ward. But then she [her midwife] was friendly enough to ask me 'Are you okay this morning?' [copying the tone of the sister's voice] Yeah I am, thanks to you." Unathi*

On asking Unathi what it meant to her when she was asked if she was okay, she had the following to say:

*"It gives me strength that I can actually do something ... because most of them ... they ... I think they just wouldn't mind ... whether I made it or didn't make it. But the one who just asked me 'Are you okay?' so maybe she - she knew that it was very hard for me [spoken softly while looking down at her lap] so that's why she's asked me if I'm okay." Unathi*

Unathi felt that the midwife had shown compassion towards her by helping her to calm down:

*"She was like 'just relax' and I was like wow, I've never had someone saying that to me, to relax and then, maybe just do it. And then I did it." Unathi*

And her interpretation and experience of the midwife's words:

*"Yeah that she actually cared about people." Unathi*

These participants might have been very young and inexperienced, but it is evident that they could immediately tell and feel when they were treated with respect, which had a more positive impact on their birth experiences. Farrah spoke about a nurse with a bad attitude towards her when she was admitted; however, she experienced the midwife as caring. The midwife helped her to get up from the bed to clean herself and encouraged Farrah during the birth; Farrah narrated this in a positive light:

*"That other lady, she was just, she was just cheeky. But that nurse, you could see she knows how to handle her patients. And ... I think that's nice because ... when I came into the ward, she helped me on the bed and she helped me get undressed and stuff like that. That, and ... she helped me with a safe delivery also. Like ... everything went well. Like, she was like ... how can I say, she was a good guide to me."* Farrah

Stacey reported an overall negative birth experience, but remembered the nurse who assisted the midwife after Stacey has given birth and who showed kindness and compassion:

*"That's the lady [pointing to a figure in her drawing] that weighed him and wiped him off. And that ... and she was writing the stuff down, how much he weighed and that. And she talked nicely to me so I liked her actually, a lot."* Stacey

Cindy gave another account of helpful and kind nursing behaviour during her stay in the postnatal ward:

*"It was okay here. Because the people are nice and friendly and they are very helpful. They have plenty of things to do, so they give their cooperation and I give mine."* Cindy



**Figure 6: Cindy's drawing**

Cindy had a positive birth experience which was also evident by the picture she had drawn during the conversation. The picture shows her smiling while giving birth (figure 6). However, most of the participants reported negative birth experiences, originating from abusive treatment towards them although they also mentioned friendly and helpful nursing behaviour as positive experiences during the births.

## **5.9 CONCLUSION**

Three essential themes were identified during the process of information unravelling. The essence of adolescent pregnancy was identified as them being mentally, emotionally and physically unprepared for childbirth. Ignorance was a huge obstacle for the participants during childbirth and they referred to their own incomplete physical development as one of the reasons why they found the whole process so challenging.

The second essential theme was yet another reason for the participants finding the experience very difficult – they felt unsettled. Almost everything that happened to them or with them was new and unfamiliar. In addition, they had to deal with certain fears and needs during childbirth. In situations where they lacked in appropriate coping mechanisms, their fear and anxiety levels were elevated, leaving them feeling vulnerable and scared. Their narratives illustrated this fact, describing in their own words how they had wanted “*my mommy*” to be there during childbirth.

Lastly, the life-worlds of the participants were divided into collective and individual themes, although the essential theme was that of an overwhelming experience. While most of the participants reported negative and dehumanising interpersonal relationships with the nursing staff, two participants reported more positive birth experiences because of receiving encouragement and guidance from the midwives. The intrapersonal experiences were unanimous among all the participants. All of them described an overwhelming level of physical pain, as well as an ‘overwhelmedness’ by emotions - from labour through to the immediate postpartum period.

The three essential themes tied in with another Husserlian concept that was identified as the central theme to the entire dissertation: an adolescent mother’s childbirth experience is that of preserving her personhood while giving birth to her baby.

## CHAPTER 6

### DISCUSSION

#### 6.1 INTRODUCTION

The central theme that emerged from this study is that of the preservation of personhood (section 6.2). In addition to the three essential themes that were identified, namely i) unpreparedness, ii) unsettled, and iii) overwhelming experience, the sub-themes and sub-categories are discussed in this chapter (sections 6.3.1 to 6.3.3) in view of existing literature. True to the Husserlian phenomenological approach (described in sections 3.3.1 and 3.3.2), the literature review was done after the information has been gathered to limit the researcher's bias during the fieldwork (McConnell-Henry, Chapman & Francis, 2009). An in-depth literature review was undertaken (as described in section 2.2) and included in this chapter (see section 6.3). The findings of related literature on middle adolescents and adult childbirth experiences are compared in section 6.4. Certain literature for nulliparous and primiparous adult women was included, based on its relevance to the adolescents' nulliparous status before childbirth. The developmental tasks of adolescents and the effect of pregnancy on these tasks are explained in section 6.5 and compared to the findings of the present study. The strengths and limitations of the study are described at the end of the chapter (sections 6.6 and 6.7).

#### 6.2 PRESERVATION OF PERSONHOOD

Personhood is defined as 'the quality or condition of being an individual person' (Oxford University Press, 2015h:1). The concept of preservation of personhood formed the central point around which the participants' narratives circled. Reports of feeling "*useless*" and experiencing undignified



treatment were common, while an act of kindness made them feel worthy of respect and valued as a human being. Three different approaches towards the preservation of personhood are discussed (section 6.2.1), namely i) a health service approach, ii) a consumer approach and iii) a holistic approach. The Midwifery Model of Care and the similarities between the model and personhood are discussed (section 6.2.2), as well as the African concept of *Ubuntu*<sup>27</sup> and how it is concerned with the preservation of humanity or personhood (section 6.2.3).

### **6.2.1 Approaches in the Health Services in Support of Preservation of Personhood in Childbirth**

Two organisations that focus on women in childbirth represent the consumer and holistic approaches at an international level and these are the White Ribbon Alliance (WRA) and the International Confederation of Midwives (ICM). The (South African) National Patients' Rights Charter represents the health service approach on a local level. All three approaches consist of rights that patients and childbearing women have when they are under the care of health care professionals<sup>28</sup>.

#### **6.2.1.1 Consumer approach**

The White Ribbon Alliance focusses on childbearing women, as consumers of health services, and their rights during childbirth. The WRA has extended patient's rights into a charter designed for childbearing women during childbirth. The objective of this charter is to enhance health education given

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<sup>27</sup> A concept from African origin referring to humanness and 'being human' (Gade, 2012:1).

<sup>28</sup> In South Africa, auxiliary nurses work in maternity settings alongside midwives. To clarify the terms, I indicate midwives or nurses separately where relevant. When I refer to both nurses and midwives I used the term 'nursing staff.'

to women who are to give birth in order to maintain their autonomy and individuality (Windau-Melmer, 2013). The findings of my study showed that the participants were not allowed any authority or autonomy during childbirth. The participants were not aware that they could voice their own opinions with regard to what they wanted or needed during childbirth. The health care professionals similarly did not invite them to act autonomously in any way regarding the birth process. Likewise, the health care professionals did not allow them to share in the decision-making regarding certain childbirth aspects such as pain relief options, the choice of a birth companion or the choice of a birth attendant. The participants expressed that they felt intimidated by the midwives and that they felt compelled to follow their orders. Respectful and dignified care and freedom from discrimination are shared objectives with the holistic approach. It was evident from my findings that the participants felt discriminated against because of the fact that they were underage. Furthermore they did not feel respected as human beings, hence the personhood of the participants was not preserved.

#### 6.2.1.2 Holistic approach

The International Confederation of Midwives' Bill of Rights focuses on both the childbearing woman and the midwife who cares for her during childbirth from a holistic perspective. The ICM values the holistic care of childbearing women as highly important in midwifery care and has compiled their own Bill of Rights for childbearing women and midwives as a recommendation for improving maternity care (International Confederation of Midwives, 2014a). This Bill of Rights has not been adopted in South African maternity settings as an official policy. However, the core of this bill speaks to the preservation of a woman's autonomy and personhood during childbirth. It is not possible to determine the competency levels of the midwives who attended the participants' births; however, the outcomes of all the babies

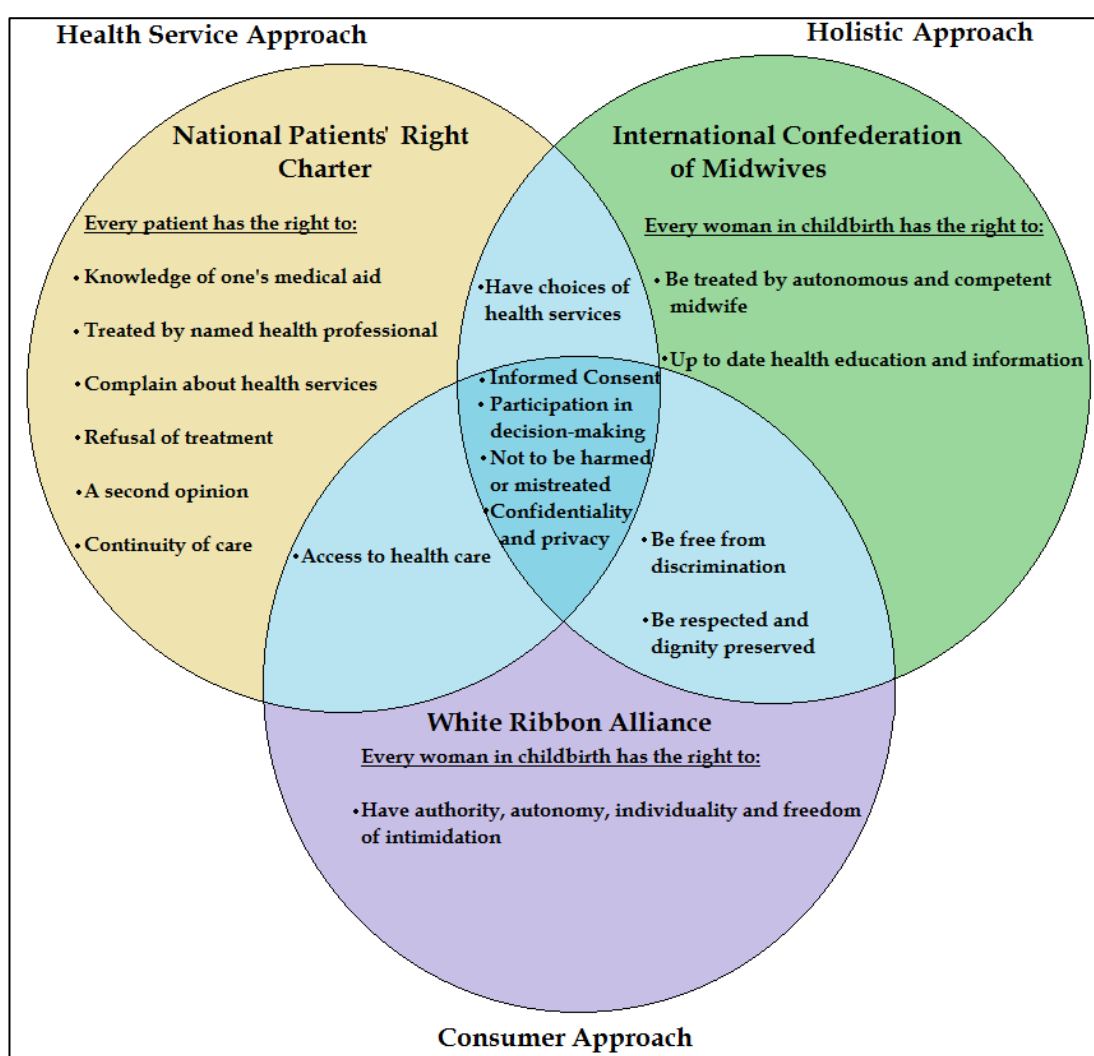
were healthy. However, the participants were not adequately educated or informed with up-to-date health information during childbirth. Since the participants' antenatal preparation was poor, it is also possible that they missed out on health education at the antenatal clinics. Although the Western Cape Public hospitals operate according to protocols, the participants were not informed of these and some of them were transferred between health care facilities without knowing why or being given any options before transfer.

#### 6.2.1.3 Health service approach

The National Patients' Charter is directed at health services at a local level, and provides for adequate accessibility and care to all patients in health facilities. South Africa's National Department of Health (DOH) encourages the concept of preserving personhood by advocating patients' rights and respectful treatment; it is, however, directed at the broad spectrum of patients in health care facilities. The charter is applicable to any patient in a health professional's care and comprises the 12 rights of a patient utilising the health system (Health Professions Council of South Africa, 2008). The preservation of personhood is directly linked to an individual's rights as a human being and, in the hospital setting, an individual's rights as a patient. All these patients' rights were applicable to the maternity settings in which the participants gave birth, since it is South Africa's only official patients' rights charter. South Africa does not currently have a midwifery model of care although such a model exists in the literature and is applicable to South African maternity settings (section 6.2.2).

The participants' recounts showed poor adherence to the patients' rights charter, since they reported that complaints about their care were not acknowledged. They were not granted the option of a second opinion and

there was minimal reported continuity of care – most of the participants were left alone for a long time after the birth of their babies, without anyone checking up on them. Seeing that they were in the public system, the participants had no need for medical aid knowledge; they all received the services free of charge. The health service approach shares one more objective with the WRA, namely access to health care, which was indeed provided to all the participants. The diagram in figure 7 is a representation of these three perspectives. It indicates the three approaches' own individual objectives, as well as where two or all approaches share the same objectives.



**Figure 7: Preservation of Personhood: Three Different Approaches Supporting Personhood in Childbirth**

The three approaches' shared objectives were mostly neglected in all the participants' cases. The participants reported no form of informed consent; they did not know why they had to undergo certain procedures, although they complied with it. The participants were not given an opportunity to share in decision-making; the health care professionals made the decisions for them, and they felt obliged to accept those decisions. Whether this acceptance was due to a feeling of intimidation or fear, or related to adolescent development, was not clear. The participants reported numerous accounts of mistreatment by the nursing staff; confidentiality and privacy, however, were not mentioned. The overall picture that the participants' narratives created shows that the health care professionals neglected to preserve the personhoods of the participants on more than one occasion. However, some accounts represented the preservation of personhood.

### **6.2.2 The Midwifery Model of Care and Personhood**

The Midwifery Model of Care described by Rooks (1999) refers to the care that midwives provide to childbearing women of all ages. The model focuses on the midwifery care of complicated as well as uncomplicated pregnancies and births from a holistic perspective. According to Rooks (1999) the aim of Midwifery is to provide a childbearing woman with care not only to ensure healthy outcomes for the mother and the baby, but also to empower the woman through her birth experience. Rooks (1999) stated that midwives value the emotional, spiritual, social and cultural impact of childbirth on a woman's life and therefore strive to make this life-changing event a positive experience. In the maternity settings in which the participants gave birth, the midwives did not hold all the values of the Midwifery model of care in high regard. However, physically healthy outcomes for all the participants and their babies were achieved. The narratives of most of the participants were riddled with unspoken emotions of sadness, anger, confusion and worthlessness. Previous studies done in South Africa also reported the lack

of adherence to basic midwifery care principles, where holistic patient care as described by Rooks' model was neglected. This matter is further discussed in section 6.3.3.2.1 (Chadwick, Cooper & Harries, 2014; Kruger & Schoombee, 2010; Jewkes & Abrahams, 1997).

### **6.2.3 Personhood and its Relationship to Ubuntu**

According to Gade (2012), the term *Ubuntu* has many different meanings, but in its essence it refers to personhood and to being human. *Ubuntu* has an African origin and refers to the humanness of someone and to the concept of valuing the community's best interest above the self (Chaplin, n.d.). It refers to caring for one another and looking after each other with a mutual understanding of 'I am what I am because of you' (Chaplin, n.d.:2). In South Africa, the *Ubuntu* concept of care was developed, which refers to having compassion for someone else's humanness (Haegert, 2000). *Ubuntu* was incorporated in the South African Constitution as an ethical guideline as well as a philosophy for people's behaviour towards one another (Haegert, 2000).

In the health system, *Ubuntu* implies caring for patients in a respectful manner while preserving their dignity and humanness (Haegert, 2000). Haegert (2000) attributed two ethical values to *Ubuntu* with the individual as the central point. First, caring in a compassionate way and showing respect towards patients, students and communities. Secondly the ethical value of personhood implies becoming more of a person through someone else. Haegert stated that 'giving personhood meaning through our nursing practice and nursing education is ethics' (Haegert, 2000:499). By Haegert's definition, the preservation of personhood becomes an ethical responsibility for nurses and midwives who care for women and, therefore, also for adolescents in labour (Haegert, 2000). Through compassionate, respectful

and dignified care the midwife can enhance the adolescent's sense of humanness and consequently preserve her personhood as well.

It was evident from the participants' narratives that they understood the meaning of *Ubuntu*, although they may not have been familiar with the concept. They expressed feeling useless when they were treated in a disrespectful manner or were ignored. Nevertheless, when they felt cared for, they expressed feeling human again. Unathi's drawing in figure 8 relates closely to Chaplin's (n.d:2) definition of *Ubuntu* as 'I am what I am because of you' as she felt that she was "okay" because of how the midwife treated her.



**Figure 8: Unathi's drawing**

### **6.3 DISCUSSION OF LITERATURE ON THEMES AND SUB-THEMES**

#### **6.3.1 Unpreparedness**

The first essential theme that emerged from my conversations with the participants was unpreparedness for childbirth. Their unpreparedness consisted of two parts: ignorance about childbirth and associated processes;

and feeling physically underdeveloped and emotionally unprepared for the demands of childbirth.

#### 6.3.1.1 Ignorance

The pregnant adolescents in this study demonstrated poor preparation and a lack of antenatal information about labour and childbirth. Although the participants had all booked their pregnancies at antenatal clinics, they were still not prepared for the reality of childbirth.

Ignorance about childbirth is a common finding among pregnant mothers of younger ages, as revealed by other studies, and is due to various reasons. These reasons include unwanted and unplanned pregnancies, unawareness of the pregnancy and fear of revealing the pregnancy to the family or boyfriend (Panday et al., 2009; Montgomery, 2003).

Montgomery described the needs of pregnant and childbearing adolescents and reported different factors that contributed to adolescents' poor attendance of antenatal classes. These factors included the following (Montgomery, 2003):

- not realising that they are pregnant at first;
- hiding the pregnancies from their families or the fathers of their babies;
- lack of transport or finances to access the clinics; and
- not knowing where to attend antenatal care.

Unlike Montgomery's findings, my study did not focus on antenatal preparation or antenatal classes; however, antenatal unpreparedness



emerged as a theme. Although different factors were mentioned with regard to poor antenatal education not all the participants necessarily experienced it. These factors mentioned by the participants include

- fear of mistreatment by the nursing staff at antenatal clinics,
- a feeling of isolation among other adolescents and a desire to withdraw from society and to hide away,
- feeling intimidated when surrounded by pregnant adult women,
- feeling ashamed of their pregnancies, and
- not accepting the pregnancy, resulting in poor attendance at antenatal clinics.

From the findings of my study and those of Montgomery (2003), it is clear that pregnant adolescents exhibit poor antenatal preparation for childbirth. Therefore, many of the adolescent mothers come face to face with the reality of childbirth only when they are already in labour. They are then surprised by the level of pain they have to endure and overwhelmed by all the procedures to which they are subjected, without understanding why (Anderson & Gill, 2014). In South Africa, clients in the private sector attend private antenatal classes for which they pay. However, during the years I have worked in the public sector, antenatal health education formed part of the everyday routine in clinics. It was, however, *ad hoc* in nature rather than planned health education sessions. These sessions usually did not focus on modes of delivery or pain relief as such. Antenatal sessions mainly covered topics such as the health of both mother and fetus, and addressed labour signs and symptoms, as well as possible complications for which women had to look out during pregnancy.

Low et al. (2003) described the differences between adolescent and adult childbirth experiences, and the factors that contributed to adolescents having a positive birth experience (refer to section 2.3.3, table 2). In concurrence with the study done by Low et al. (2003), I also found that adolescents were ill prepared for childbirth and did not put in a lot of effort to prepare for the labour, birth or postpartum period.

All the participants in this study were from lower socioeconomic backgrounds, often lacking finances; thus private antenatal classes were not necessarily affordable. With the evidence showing that many adolescents book at antenatal clinics often in late pregnancy, it means that they miss out on a considerable amount of health education during the first part of their pregnancies (Mkhwanazi, 2010; Montgomery, 2003).

However, poor preparation for childbirth is not specific to adolescents. Studies found that being prepared for birth and knowing the signs and symptoms of complications are limited among pregnant women in general (Bintabara et al., 2015; Kabakyenga et al., 2011). More programmes are necessary to raise an awareness of birth preparedness and knowledge of possible complications (Acharya et al., 2015).

#### 6.3.1.2 Physically and emotionally unprepared

The fear of being physically and emotionally unprepared for childbirth which the participants in this study expressed is not an uncommon feeling among expectant mothers. Pregnant women mentioned these feelings in studies that were done to explore factors contributing towards the fear of childbirth (Matinnia et al., 2015; Anderson & Gill, 2014; Garthus-Niegel et al., 2011; Fenwick et al., 2009). Garthus-Niegel et al. (2011) investigated the fear of childbirth among Norwegian women of all ages and included primiparous

and multiparous women. The Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) was utilised and completed by the participants (Garthus-Niegel et al., 2011). The W-DEQ is a psychometric questionnaire that was developed to determine the level of fear of childbirth in pregnant women and women during childbirth (Wijma, Wijma & Zar, 1998). The results of Garthus-Niegel et al.'s (2011:160) study showed that the 'lack of self-efficacy' - the lack of feeling confident, strong and independent - was higher in primiparous women. It was also highlighted as an important factor influencing how women cope with the fear of childbirth (Garthus-Niegel et al., 2011). As multiparous women had given birth before, they might have been more confident that they were physically capable to manage the childbirth (Garthus-Niegel et al., 2011).

Fenwick et al. (2008) also used the W-DEQ questionnaire to explore the relationship between the levels of fear of childbirth and the outcomes of childbirth among Australian women of all ages and parities. One concern that the participants have raised was being unprepared for the birth or not being prepared enough to face the challenges of childbirth; ages and parity were not, however, specified (Fenwick et al., 2009). Their findings showed no association between the level of childbirth fear and the method of delivery, despite the fact that the participants reported high levels of fear of childbirth (Fenwick et al., 2009).

Matinnia et al. (2015) explored the factors that influenced first-time mothers to choose caesarean deliveries above vaginal births in four health facilities in Iran. From six identified categories of fear of childbirth, one category comprised women's feelings about their own competencies and responses during childbirth and more than half of the women reported the fear of being physically incapable and incompetent for a vaginal birth (Matinnia et al., 2015). A comparison between women who chose vaginal birth and women

who chose caesarean deliveries showed that the majority (64%) of the women who chose caesarean deliveries were fearful that they were physically unable to have a vaginal birth compared to those (39.1%) who chose vaginal births (Matinnia et al., 2015).

Lupton and Schmied (2013) explored women's experiences of embodiment during the birth of the baby and how the mothers had felt at that specific moment. The researchers reported that the women described a fear of being physically torn apart when the baby is born and that they were losing control over their bodies during this phase. These mothers did, however, experience a sense of achievement and relief afterwards (Lupton & Schmied, 2013; Montgomery, 2003).

Salomonsson et al. (2013) explored the connection between the level of childbirth fear and childbirth self-efficacy – the confidence in the ability to manage certain challenges in order to achieve a goal such as childbirth – among nulliparous pregnant women of all ages. The W-DEQ (version A) questionnaire was used to determine the level of childbirth fear, and the Childbirth Self-efficacy Inventory (CBSEI) was used to determine the level of self-efficacy among the participants. The CBSEI is an instrument developed by Lowe (1993) to determine outcome expectancies (giving birth) and self-efficacy expectancies (ability to cope with labour and childbirth and pushing a baby out) of women above 18 years during active labour and the birth process. Salomonsson et al. (2013) found that more than half of the participants in their study who reported a severe fear of childbirth were also part of the group with the lowest self-efficacy expectancy – participants with the lowest confidence in their abilities to cope with childbirth (Salomonsson et al., 2013). Therefore pregnant women with a severe fear of childbirth and a decreased level of confidence in their own abilities are at a bigger risk to

become more fearful as the pregnancy progresses and to find labour and giving birth very distressing (Salomonsson et al., 2013).

Although a considerable amount of literature is available on women and their fear of childbirth and level of self-efficacy, there is a dearth of research on adolescent self-efficacy during childbirth. Only one study was found. The study was done by Ford et al. (2001), who explored adolescent mothers' (below 20 years of age) levels of self-concept and self-efficacy of before they gave birth, as well as during the postpartum period after an antenatal care intervention has been implemented. The intervention involved the adolescents being taught how to look after their own and their unborn fetuses' health by involving them in their own antenatal care such as blood pressure monitoring, urine dipstick checks, weight and fetal heart auscultation (Ford et al., 2001). Their findings indicated that the adolescents' levels of self-concept and self-efficacy of childbirth increased after giving birth, although their self-efficacy with regard to self-care and new-born care was reduced after giving birth (Ford et al., 2001). The authors reported no significant differences in the levels of self-efficacy between different age groups (Ford et al., 2001).

Montgomery (2003) aimed to determine factors that may influence adolescents during labour and increase their anxiety and fear of childbirth. Some of the factors that were mentioned included the fear of painful labours, the possible fear of the hospital environment and also of 'splitting open' when giving birth (Montgomery, 2003).

The participants in my study expressed that they felt concerned during labour about their bodies not being developed fully to accommodate the fetus during the birth process. One participant expressed that she felt scared that she might "*squeeze*" her baby. This concern, however, relates to

adolescent pregnancies and not adult women's pregnancies due to an underdeveloped pelvis and associated cephalo-pelvic disproportion (see definition of CPD on page 19) that has been the main cause for obstructed labour in many adolescent childbirths (Ganchimeg et al., 2013; Shaikh et al., 2012; Cronjé, Cilliers & Pretorius, 2011). Adult women experience complications with CPD during childbirth due to various reasons such as short statures, diabetes mellitus and large fetus (more than 4 000g), or medical reasons such as pelvic shape or injury (Cronjé, Cilliers & Pretorius, 2011). In contrast with adults, CPD in adolescents may be caused by the above as well, but the main cause of CPD is an underdeveloped pelvis that obstructs a fetus' descent through the birth canal (Cronjé, Cilliers & Pretorius, 2011).

During the field work, I frequently had to bracket my thoughts and feelings about the research, seeing that the conversations with the participants elicited certain emotions in me. I found their admission of emotional and informational unpreparedness for childbirth challenging and their physical unpreparedness concerning, as I often see this in my workplace – the struggle among adolescent mothers to cope with labour and afterwards with their new-born babies. I captured my thoughts and emotions in a reflective journal throughout this study as part of the bracketing process in order to set aside my own feelings. I reflected on every conversation with a participant, using these reflections. An extract of such an entry is presented below.

#### Reflective Journal: 25 January 2015

*I find myself in a conflicted position at the moment. After another conversation with a young mother I am torn between my empathy for her and my own feelings about my research. I am currently feeling slight resentment towards all adolescent mothers for bringing this upon themselves. I envision that the cycle of poverty will never be broken because of a lack of insight from adolescents. They do not know about the*

*demands of raising a child as they are still children themselves. From their own accounts they expressed that they were probably too young to become mothers and that they were not prepared for motherhood, emotionally or physically.*

*By the time these adolescent mothers reach adulthood and have a better understanding of life, their children are already almost adolescents themselves. Then it is too late to attempt to impose decent values onto them if they did not learn these yet. Then the cycle of poverty continues because now these children are not always raised to think about making smart choices; the vast majority grow up and learn about surviving with limited finances and living with their grandmothers most of the time. They learn to be independent at a young age as their adolescent mothers often go back to school to study or start working in order to earn money. Often the grandmothers are old and not very active themselves, which leave the children to their own accord and to that of their friends, learning about life together. What will eventually happen to the babies of the adolescent mothers I have spoken to?*

*If I envision coming from a poor family and having a mother of 15 years of age who is not around when I grow up because she has to work or finish her education, I am inclined to wonder how I shall keep myself occupied. I shall probably explore the world. If a role model or adult figure is absent in my life, I shall probably attempt to learn things by myself. The possibility exists that I might follow in my mother's footsteps because I do not know any better and am left to my own accord to discover the world ... Thus by the time I realise I have fallen pregnant myself (or if I am a boy, my girlfriend is pregnant) I realise - just like my mother did when she was a pregnant adolescent - that all the choices I make have consequences and some are bigger than others ... Then the cycle starts anew; I am an adolescent mother with a new baby. Now I have to leave the care of my baby to now great-grandmother so I can finish my education or find employment, as my own mother is also still working to sustain the family. Once again, a new baby has to grow up without a mother because I am doing the best I possibly can to give him the best upbringing with the knowledge I have at the age of 15 ...*

*I do empathise with these adolescents but I also feel like grabbing them by the shoulders and asking if they ever considered the consequences of their actions? The consequences of falling pregnant and then moving forward? Did they consider the future of this infant they are holding now; are they able to provide this baby with the best chances and opportunities in life and to present a respectable person to the world one day? Have they ever thought about the huge responsibility they have to raise a child?*

*I have my doubts about the percentage of adolescent mothers who manage well and who do not just continue with their poverty cycle and have yet three more babies with three more different fathers in the future, never breaking this doomed cycle. My biggest concern remains – what happens to these adolescent mothers and their children when they leave your ward and head home. Will they be all right?*

### **6.3.2 Unsettled**

The second essential theme that emerged from the conversations was their state of mind during childbirth. The participants felt unsettled by various processes that resulted in a heightened sense of fear during childbirth and releasing their control to the midwives' authority. They expressed needs as coping strategies that helped them to cope with childbirth: their mothers as birth companions and ongoing reassurance from the nursing staff.

#### **6.3.2.1 Fearful**

The heightened sense of fear was expressed by the participants in terms of the following: the fear of being alone, fear of their babies' well-being, fearful of the mistreatment by the nursing staff and fearful due to a lack of communication with the nursing staff.



#### 6.3.2.1.1 Fear of being left alone

All the participants expressed that they had wanted someone to stay with them during the entire course of labour. One participant mentioned how it had helped her when a nurse massaged her back while her mother was not allowed inside the labour room. The participants needed someone to be with them. They felt that it would have helped them to calm down and would have made them feel supported.

Many hospitals and maternity units in South Africa allow a woman in labour to have a birth companion at her side during labour, who acts as emotional and physical support. The intention of a birth companion is for women in labour to not be on their own, since childbirth can be a fearful event for a first-time mother - whether she is under midwife or obstetrician care (Christiaens, Van De Velde & Bracke, 2011).

Studies have shown the benefits of a birth companion and continuous labour support pertaining to birth outcomes for both mother and baby (Ross-Davie & Cheyne, 2014; Shah, Gee & Theall, 2014; Hodnett et al., 2013; Amorim & Katz, 2012; Baker, 2010; Brown et al., 2007). Some of these benefits include a reduction in the caesarean and assisted birth rates, an improvement in Apgar<sup>29</sup> score after five minutes and a more positive and rewarding birth experience for mothers.

The concept of doulas had been a part of pregnant and labouring women for some time. The doulas are not medical professionals but are trained in relaxation techniques and supportive behaviour. These doulas act as support

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<sup>29</sup> A score given out of ten at one minute, five minutes and ten minutes after a baby is born that indicates the need for resuscitation (Cronjé, Cilliers & Pretorius, 2011).

instead of, or in addition to, a partner or mother's support of the woman in labour (Ahlemeyer & Mahon, 2015; Wombs, 2015; Hunter, 2012; Koumouitzes-Douvia & Carr, 2006; Scott, Berkowitz & Klaus, 1999). Studies have shown the effectiveness of having a trained support person caring for a woman in labour (Hunter, 2012). These studies found that the continuous presence of a birth companion in the person of a doula is advantageous to the mother in labour. It helps her to not feel that she is alone, but rather supported, during this challenging time.

Childbirth is an important and life-changing event in a woman's life. Regardless of the number of births she has had, a woman experiences a turmoil of emotions ranging from fear and uncertainty during labour to excitement once the baby is born and she becomes a mother. Her body changes and adjusts to the demands and processes of birth. In addition to the demands of childbirth, the participants also faced the challenges of their developmental tasks during adolescence, as described by Erikson's eight stages of the life cycle (Erikson, 1968). Drake (1996) described the impact of pregnancy on adolescents by using Erikson's (1968) identity versus role confusion and Mercer's (1990) developmental tasks (see section 6.5). Childbirth is an emotionally, psychologically and physically challenging time. It is a moment in a woman's life that leaves her vulnerable, and she needs emotional support during this time (Ross-Davie & Cheyne, 2014; Hodnett et al., 2013; Amorim & Katz, 2012; Sauls & Grassley, 2011; Brown et al., 2007; Sauls, 2004; Scott, Berkowitz & Klaus, 1999).

Studies have shown that being alone during labour can lead to young adolescents feeling more stressed and anxious, as well as more fearful of the imminent birth (Anderson & Gill, 2014; Sauls, 2006; Montgomery, 2003). However, having a support person at her side during labour did not emerge as a theme in only this study. Many studies over the years regarded this

aspect as one of the most important supportive needs of any woman in labour, despite her age or parity (Anderson & Gill, 2014; Hodnett et al., 2013; Cipolletta & Balasso, 2011; Sapountzi-Krepia et al., 2011; Sauls, 2006; Sauls, 2004; Low et al., 2003; Campero et al., 1998). My findings concur with the above-mentioned studies that women do not want to be alone during childbirth; they want birth companions with them during this period. The adolescents were fearful of being left alone and felt abandoned if no one was available to provide comfort or reassurance. The participants all expressed their desire to have their mothers as birth companions, which is discussed in more detail in section 6.3.2.3.1. Although a search was conducted, no literature could be found that contradicted the advantages of having a birth companion present during childbirth.

#### 6.3.2.1.2 Fear of the baby's well-being

The participants expressed certain concerns and uncertainty regarding their labours and giving birth. They wanted to know that their babies were still well and needed reassurance that the babies would not be harmed during the birth by “squeezing” them or not pushing as they were told. Childbirth is not always a straight forward process. Often the media - television, radio, books and newspapers - gives people the wrong impression of labour and birth with horror stories about these processes being full of complications (Asp et al., 2014; Morris & McInerney, 2010; Low et al., 2003). It is common for the media to dramatise such portrayals. These portrayals are not consistent with evidence-based midwifery care and, as a consequence, leave health care professionals in a difficult position with regard to providing women in labour with health education (Morris & McInerney, 2010). These often misleading displays of childbirth can influence women's perceptions and fear of childbirth, as reported by Morris and McInerney (2010); a third of

their participants experienced increased anxiety after being shown birth shows on television.

The participants' unpreparedness for childbirth extended further than just a lack of knowledge about the birth process. This was evident from the fear for their babies' health, which was often based on ignorance. One participant feared that she might "*squeeze*" the baby's neck during the birth process. Such fear could have been addressed during antenatal education sessions and the participant reassured.

#### 6.3.2.1.3 Fearful because of a lack of communication

It was apparent that the nursing staff's lack of communication contributed to the participants' concerns, since their questions during labour were often not answered, leaving them uninformed. One participant felt unsafe and scared for her baby's well-being because of the manner in which some nurses and midwives treated her, as well as their negative "*attitudes*". Chadwick, Cooper and Harries (2014) also found that their participants experienced distress and concern for their own and their babies' health as a result of being ignored by midwives and a lack of information about their progress of labour. Sauls (2010) reported that following pain management, the second and third most important supportive nursing behaviours that adolescents experienced during childbirth were respectful treatment and friendly, kind nurses who made them feel welcome.

There is a lack of research focusing on adolescent-midwife communication and relationships during childbirth. A small number of studies suggested that health care professionals who work with pregnant adolescents should care for them with a non-judgmental approach and should demonstrate, by means of verbal and non-verbal communication, that they are listening to the adolescents and taking them seriously (Magness, 2012; Podgurski, 2000).

One study explored the impact of health care professionals' behaviour on women's birth experiences and highlighted communication between the patient and staff members as essential. Baker, Choi and Henshaw (2005) found that the relationship between the mother and her midwife might be negatively affected and leave the mother feeling disempowered if the midwife assumes a position of control over her labour and if she does not allow the mother to voice her questions and/or opinions.

One of the participants, Unathi, narrated that the *"belts were too tight"* when she was attached to the cardiotocograph (CTG) monitor and that she believed the midwife's explanation that it *"was the best for the baby"*, although she did not understand why. In secondary and tertiary level hospitals, such as the one to which Unathi was admitted, it is standard procedure to attach these leads to mothers with high risk pregnancies for certain periods of time, based on the premise that changes in the fetal well-being can be picked up immediately. Even though the procedure might be necessary, it is important for the patient to understand exactly how this will benefit her and her baby. As long as the midwife bears in mind that she does not cause the patient unnecessary discomfort during any procedure and not minimises a patient's complaint. As in Unathi's situation, sometimes these belts may actually cause a patient significant discomfort due to excessive tightness. Regardless of their ages and parity, women need to be kept updated about their progress during labour and how their babies are coping with the labour. Most maternity patients do not have the medical background to understand the labour process or comprehend the complexities of CTG monitoring. They are therefore dependent on the health care professionals to inform them as much as possible about their situations in order for them to not be mere passive receivers of nursing care (Baker, Choi & Henshaw, 2005).

Sauls (2010) recommended practical guidelines for nurses who work with adolescents during childbirth, one of which was to frequently explain what is happening with them and how labour is progressing instead of waiting for them to ask questions. The nurse or midwife needs to anticipate possible questions that the adolescent might have and offer her the information upfront (Sauls, 2010). Peterson et al. (2012) highlighted the need to establish an adolescent-midwife relationship as an important factor. Such a relationship will give the adolescent confidence to ask questions and to establish open communication channels, since it will make her feel safe and comfortable.

#### 6.3.2.1.4 Fear of mistreatment by the nursing staff

Based on the demeaning nursing (midwives and nurses) treatment to which some of the participants were subjected during their pregnancies, they feared the treatment that they would receive from the nursing staff during childbirth. The participants narrated that they were afraid to be left alone, shouted at or humiliated in front of other patients.

*"When she went to the other patients, she treated them nice but when she came to me then she was like shouting." Farrah*

Although certain behaviour of nurses may not be directly disrespectful or intended as mistreatment, the patient may experience it as such. When a midwife leaves a patient alone for a long time, the patient may feel neglected (Chadwick, Cooper & Harries, 2014). Even though the midwife may have been busy with birth documentation or attending to another patient, if this was not communicated to the patient, it may lead to a misunderstanding and the patient feeling neglected.

Legal policies and regulations regulate the nursing profession to ensure that nursing practice is of an accepted quality for all. This includes the Scope of Practice for Nurses that guides the professional and ethical behaviour of nurses and midwives in South Africa (Department of Health, 2013b). The Scope of Practice requires midwives and nurses to practice their professions in an ethical manner and to prevent harm to their patients. The participants' fear of being mistreated by the nursing staff indicates that the scope of practice has been violated during their antenatal care, creating anxiety among the participants regarding repeat incidents during childbirth.

Mattinia et al. (2014) found that the majority (90.1%) of the participants from their study – childbirth-related fears causing primiparous women to choose caesarean deliveries over vaginal births – were fearful of the competence and actions of health care professionals during childbirth (Matinnia et al., 2015). In relation to this fear, most of the women feared that the health care professionals would not support them in the maternity wards and that they would not be treated with respect or dignity (Matinnia et al., 2015). Reasons for this particular fear, as indicated by the authors, were more guesswork than factual information. However, health care professionals' unsupportive behaviour and a lack of trust in them were mentioned as plausible explanations (Matinnia et al., 2015).

Christieans, Van de Velde and Bracke (2011) explored the fear of childbirth in women and compared maternity care models in midwife- and obstetrician-led units in Belgium and the Netherlands. The authors found that a woman's fear of childbirth is influenced more by her interpersonal relationship with her health care provider than by the health care facility or the system she uses (Christiaens, Van De Velde & Bracke, 2011). They found that the medicalisation of childbirth had a negative impact on doctor-patient interaction in both countries, seeing that women who gave birth under

obstetrician care were less satisfied with their childbirth experiences than those under midwifery care (Christiaens, Van De Velde & Bracke, 2011).

The ICM code of ethics for midwives provides a framework that midwives can adapt and adopt in their practice settings. The code focuses on different aspects of midwifery, of which one is midwifery relationships. This refers to midwives' responsibilities to themselves, the relationships between midwives and patients and between midwives and other health care professionals (International Confederation of Midwives, 2014b). The midwifery relationships are in part described as midwives developing partnerships to empower childbearing women to speak for themselves and to encourage shared decision-making with patients. The midwives work jointly with other health care professionals to ensure the best outcomes for the mother and the baby (International Confederation of Midwives, 2014b). In addition to the ICM's ethical values, the Midwifery Model of Care also serves as a foundation for the development of an ethical code for midwives to ensure the holistic care of their pregnant clients during childbirth (Rooks, 1999).

The findings from my study has shown that although the participants and their babies achieved the best physical outcomes of childbirth which are physically healthy mothers and babies, the participants did not receive holistic care and did not feel empowered during childbirth. The midwife-patient relationships were not as effective as the participants were not encouraged to voice their opinions and they did not take part in any decisions regarding their labours or births. The participants relied on the midwives' compassion and competence to assist them during labour with pain relief, encouragement and reassurance and during childbirth to guide them through the birth. However, all of the above were not initially offered by the midwives or nurses but provided (and in certain cases not provided at



all) only when the adolescents asked for it. The participants felt that they have survived childbirth rather than were empowered by it.

#### 6.3.2.2 Submissive

Although the participants abdicated their autonomy to the nursing staff who cared for them during childbirth, they expressed that they wanted to be involved in certain aspects of their care. They wanted to be heard and respected in addition to having a sense of autonomy in the management of the labour process.

The participants all needed instructions during the second stage of labour on how to push. All of them reported that they had just followed the midwives' instructions and that they believed this to be the reason why they had safe deliveries. All six participants mentioned that they would advise future adolescent mothers to just listen to the midwives and do as they say.

On releasing control over their bodies and actions to the midwives assisting them, the participants lost their voices and participation in decision-making as well. The woman and her health care provider should share the decision-making during pregnancy and childbirth, and the woman in labour should not have to submit her autonomy (Nieuwenhuijze et al., 2014; Nunes et al., 2014).

No woman should face a list of choices or decisions to be made for the first time she when is in labour; ideally her choices should be communicated with her during her pregnancy so that she can make informed decisions and exercise her choices (Nieuwenhuijze et al., 2014). However, the participants in my study were ill-prepared for childbirth. They were not well informed about the choices available and submitted to any person they regarded as an authority figure. Once adolescents feel that they are seen as 'bad mothers' it

makes them feel incompetent and not in control of the situation (Breheny & Stephens, 2007:120). In order for adolescent mothers to feel supported and confident in themselves they need to be freed from the adolescent-mother generalisation and cared for as new mothers instead of bad mothers.

#### 6.3.2.3 Needs expressed by the participants to cope with their unsettledness

In order to cope with the unsettledness that the participants felt during childbirth they relied on certain needs as coping mechanisms. One need was expressed to have their mothers with them as birth companions, and a second need was to have ongoing reassurance and encouragement from the nursing staff and their mothers during childbirth.

##### 6.3.2.3.1 Mother as birth companion during childbirth

The participants described their individual relationships with their mothers and what it meant for them to have their mothers with them during labour. Two participants described their mothers as being her *"best friend[s]"* and *"being like an angel"* watching over her. The description of seeing her mother as an angel by this participant was also described by James (1997) where she found that women and midwives often experience the relationship between the woman in labour and a female relative in a similar way. In this study, no fathers accompanied the participants in labour – only one father was mentioned during the phenomenological conversations.

Anderson and Gill (2014) measured the effects of fear, a lack of knowledge and the baby's father being absent during births on adolescents and found a notable difference between the different adolescent age groups. The presence of the mother as support person in my study is consistent with Anderson

and Gill (2014) who found that younger adolescents, between 13 and 16 years of age, reported had less partner involvement and labour support during childbirth. The birth companion seemed to have had the biggest influence on the younger adolescents' birth experiences; all the younger adolescents' mothers were with them during labour (Anderson & Gill, 2014). The older adolescents mostly had either their mothers or a different birth companion, while some laboured alone. Anderson and Gill (2014) also reported that the babies' fathers were absent, but to a lesser extent than with the younger adolescents.

Support, however, is not supposed to start only once the adolescents are in the labour room, but should be a continuation from the pregnancy period. Logsdon et al. (2005) explored the social support structures that were available to adolescents during their pregnancies and found that the babies' fathers did not support the mothers adequately during their pregnancies. The authors suggested that the girls' own mothers are in the best position to support them, seeing that they already live with them; they thus know best what their pregnant daughters need (Logsdon et al., 2005). This finding might explain the mothers' presence as birth companions instead of the babies' fathers, as reported by different researchers (Anderson & Gill, 2014; Khresheh, 2010; Montgomery, 2003), which is consistent with the participants in my study. If the mother of the adolescent is not available, a female relative's presence has been found to be effective as well (Hodnett et al., 2013; Khresheh, 2010; Montgomery, 2003).

#### 6.3.2.3.2 Ongoing encouragement and reassurance

A woman in labour's birth companion can provide reassurance only up to a point; then it moves towards the midwife's scope of practice and responsibility to reassure the patient that her labour is progressing well and

that she and her baby are both still healthy. The scope of practice for midwives in South Africa states that a midwife shall promote, maintain, restore and support the health status of the mother and her child during pregnancy, labour and postpartum (Department of Health, 2013b). Knowing that everything else is going well will encourage a labouring mother to keep going.

In her study, Sauls (2004) focused on adolescents' experiences of nursing support during labour. She found that the adolescents as a group indicated being praised by the nurses to be the most important supportive measure, followed by pain management. The adolescents also ranked measures such as the nurse helping them to relax and keeping them from feeling overwhelmed in the top 10 supportive behaviours. Middle adolescents expressed that they needed supportive care in the form of affirmation and encouragement most (Sauls, 2004).

The participants in this study expressed their need to be encouraged throughout the labour process, especially during the second stage of labour when they started pushing. They needed clear instructions on how to push and if they were doing it right. Sauls (2010) maintained that nurses, in order to ensure that adolescents experience childbirth more positive, can follow important support measures such as assistance during labour and childbirth and providing guidance through the unknown.

However, it appeared that these experienced feelings were not specific to adolescents. Studies were found that indicated that nulliparous women also needed encouragement and reassurance during the second stage of labour (Borders et al., 2013; Sampsel et al., 2005). Borders et al. (2013) described midwives' verbal support to nulliparous women during the second stage. Supporting the woman's spontaneous pushing and continuing to encourage

her throughout the birth were highlighted as important factors (Borders et al., 2013).

### **6.3. Overwhelming Experience**

The third essential theme was identified as 'childbirth is an overwhelming experience'. Sub-themes and sub-categories were identified from the conversations with the participants. The term 'overwhelmedness' describes the *life-world* of the participants during childbirth, which refers to their reality or truth of the experience.

#### **6.3.3.1 Intrapersonal experiences**

The participants' intrapersonal experiences were divided into two sub-categories, namely of 'overwhelmed by pain and overwhelmed by emotions. during childbirth which were pain and emotions.

##### **6.3.3.1.1 Overwhelmed by pain**

The participants in this study described their labour experiences as very painful. They narrated how the contractions' intensity during labour affected them to the point where they felt they could no longer cope with the pain. One participant expressed that she felt as if she was going to die. They recounted pain relief to be their top priority during childbirth. This was consistent with Sauls' (2010) study in which the objective was the promotion of positive childbirth experiences among adolescents. Sauls (2010) also stated that adolescents reported pain relief to be the most effective support measure that nurses could offer them during labour.

The pain experienced during labour and childbirth is not limited to adolescents only but to every woman in labour (Sawyer et al., 2011). Whether

it is her first or fourth pregnancy, studies have shown that all women in labour reported some level of pain during labour and childbirth. Their perceptions of the pain, however, depend on their views of labour pain, their coping mechanisms and being able to make decisions about their pain management (Cipolletta & Balasso, 2011; Bryanton et al., 2008; Goodman, Mackey & Tavakoli, 2004).

This study focused specifically on middle adolescents and their reports of feeling overwhelmed by the level of pain they had experienced. Limited studies have been done on the subject of adolescence and childbirth, and no studies were found that focused solely on middle adolescents. However, Zasloff, Schytt and Waldenström (2007) found that younger women between the ages of 15 and 25 years reported more painful labours and increased fear during childbirth than older mothers. This demonstrated that childbirth experiences vary depending on the mother's age.

There is a dearth of research in the field of adolescents' childbirth experiences, including their experiences of pain during labour. Providing pain relief, however, not only refers to the administration of analgesia (pain medication) to patients during labour, but also includes alternative methods to alleviate the pain such as massage, music, birthing balls, hot or cold compresses (bean bags or ice packs) or changing position (Wombs, 2015; Hunter, 2012; Taavoni et al., 2011; Kimber et al., 2008; Sauls, 2006). The birth companion or doula may provide these strategies (Wombs, 2015; Amorim & Katz, 2012). Some studies advocate epidural analgesia as the most effective pain relief option (Ho et al., 2013; Akerman & Dresner, 2009). However, access to epidural pain relief may be limited or unavailable in the public hospital sector.

To provide effective and appropriate pain relief, the level of pain needs to be established. Pain assessment measures are available to assist health care professionals in establishing the pain levels of women in labour; none was, however, found for adolescents in labour (Wickboldt, Savoldelli & Rehberg-Klug, 2015; Bergh et al., 2012; Roberts et al., 2010). The existing tools and scales mentioned in current research include the following: the use of a handgrip force to determine the intensity of uterine contractions (Wickboldt, Savoldelli & Rehberg-Klug, 2015); an algorithm for use during labour with suggested nursing actions (Roberts et al., 2010); and visual scales with numbers or facial expressions for patients to rate their pain levels (Bergh et al., 2012; Bergh et al., 2011). The applicability of these assessment tools for adolescents in labour has not been tested as yet but may be as effective to establish pain levels in adolescents as in adult women.

In Sauls' study (2004), almost a third of the adolescents reported not being offered pain relief by the midwives at all during childbirth. A midwife who cares for a labouring woman can express empathy in different ways. By offering pain relief, assisting with relaxation techniques, informing the woman about her progress and reassuring the support person (Adams & Bianchi, 2008), the midwife makes the woman feel more understood and that she is not alone during this process.

#### 6.3.3.1.2 Overwhelmed by emotions

The participants recounted that the nurses and midwives who looked after them during childbirth lacked empathy for the situation in which the participants found themselves. They were treated with impatience and rudeness. They also mentioned that they needed the nurses to understand what they were experiencing, as they did not understand the process that their bodies were going through. Midwives and nurses' attitude towards

adolescent mothers can greatly influence their childbirth experiences in positive or negative ways (Magness, 2012).

Anderson and Gill (2014) explored fear and psychological birth trauma associated with childbirth in adolescents of different ages. They did a cross-sectional study during which 201 adolescents completed questionnaires using the Impact of Event (IES) scale. This scale was designed to evaluate psychological birth trauma. The authors found that despite their ages, more than half of the younger adolescents reported an extreme level of fear – rated at four or five on a scale from one (none to slight) to five (very much). The fear of losing control and the fear of dying were present among all age groups.

#### 6.3.3.2 Interpersonal experiences

The participants' recounted interpersonal experiences were mostly negative, although positive experiences were also reported in terms of the nursing staff's encouragement and kindness. The participants' negative experiences were based on reports of the nursing staff's mistreatment of them during childbirth, which made them feel dehumanised.

##### 6.3.3.2.1 Dehumanised

The negative experiences that the participants narrated were related to the nursing staff's dehumanising treatment of the participants and originated from them feeling unimportant, ignored, victimised and disrespected.



#### 6.3.3.2.1.1 Felt unimportant

Although the participants found themselves in an unfamiliar environment during the labour process, they were still able to comprehend the type of care that they received. All the participants recalled in detail what was said to them in a demeaning or praising manner and how they noticed their surroundings, even though they were silent and inexpressive to the nurses or midwives about it.

Dehumanising treatment and abuse of pregnant and labouring women of all ages in health care facilities has been reported by numerous researchers (Lukasse et al., 2015; McMahon et al., 2014; Elmir et al., 2010; Swahnberg, Thapar-Björkert & Berterö, 2007). One such a study used a meta-ethnographic approach to search for literature on women's experiences and views of traumatising births (Elmir et al., 2010). The authors reported that women felt invisible and out of control, and wanted to be treated humanely.

The narratives of rudeness and unprofessional behaviour in the labour room, as recounted by the participants, are not new trends in the South African public health care facilities. Although limited research has been done on women's experiences of intrapartum care during childbirth in South Africa, three studies were found in which abuse in maternity settings was explored (Chadwick, Cooper & Harries, 2014; Kruger & Schoombee, 2010; Jewkes, Abrahams & Mvo, 1998).

One such a study was conducted in Cape Town with the objective of determining why nurses<sup>30</sup> abuse patients during pregnancy and childbirth.

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<sup>30</sup> Jewkes, Abrahams and Mvo (1998) used the term 'nurses' in their study that implied midwives and nurses; therefore their terminology was adopted and only used with regard to their study.

Patients and nurses from different obstetric services were interviewed for this study, following an ethnographic approach (Jewkes, Abrahams & Mvo, 1998). The participants were from Black and Coloured origins. Jewkes, Abrahams and Mvo (1998) found the following:

- Nurses treated patients inhumanely
- Patients were scolded for anything they do wrong according to the nurses
- Patients rationalise their treatment using the nurses' behaviour
- Nurses' standpoints with regard to their own attitudes and behaviours showed their justification of seemingly abusive acts and gestures towards patients
- Nurses' concerns about their professional status in the community and professional support in the health care setting
- Nurses exerted threats of abuse towards patients to maintain power and control
- Nurses' perceived ideas of patients as inferior to nurses

Jewkes'et al's (1998) research was conducted 18 years ago, yet the narratives of the participants in my study described similar experiences of abuse. As recounted by participants in Jewkes' research, participants in my study also reported being shouted at in front of other patients during their antenatal visits, as well as being ignored during labour when they asked the midwives questions.

A more recent study undertaken in Cape Town explored factors that contributed to women of all ages' negative birth experiences in public hospitals, as well as to their experiences of abuse in the maternity units

(Chadwick, Cooper & Harries, 2014). Four themes were identified from the women's birth stories after analysing the participants' narratives. These themes are i) 'negative interpersonal relationships with health care professionals, ii) a lack of information, iii) neglect and abandonment, and iv) absence of a labour companion' (Chadwick, Cooper & Harries, 2014:864).

Similar to Stacey's story about having to clean up the blood on the floor, a woman in Chadwick et al.'s (2014) study was also told to mop up the floor where blood was spilt during the birth. The authors describe this kind of nursing behaviour as one of sending a message to women in childbirth that they are not worthy of receiving professional care or respect for their dignity (Chadwick, Cooper & Harries, 2014). Stacey described how embarrassed she felt about messing blood on the floor and how she knelt down to clean the blood from the floor with her facecloth. She had clearly received the nurse's message that she was not worthy of respect and that the said nurse also did not respect her dignity. Chadwick et al.'s (2014) findings, however, pertained only to women aged 18 to 42 years. Chadwick et al.'s study did not include the younger adolescent age group. Nevertheless the findings are similar to those of my study. It appears to be a phenomenon that is not reserved only for adolescents but for many women in labour.

Reportedly, some of the participants in Chadwick et al.'s study felt as if they had become objects without feelings and not in possession of their own bodies. This concurred with the experiences of the participants in my study who reported feeling "*useless*" and being regarded as insignificant. Farrah recalled being treated like "*You're a kid man*" by "*bossy*" and "*cheeky*" nurses. Treating a woman with respect and dignity during childbirth should not require a great deal of effort from any individual. Women in labour are in a very vulnerable position and the smallest demonstration of care and humane treatment can turn their experience into a positive birth experience devoid of

trauma and feeling that their bodies had been violated (Chadwick, Cooper & Harries, 2014).

Crowther, Smythe and Spence (2014:24) explored the mood that women and their birth companions, the midwives and obstetricians experienced during the birth process and how different actions or events, described as the 'attunement' to birth, influenced the mood. They found that disturbances during birth, for instance people entering the room, bright lights and interventions, can disrupt the peacefulness of a birth and increase a mother's anxiety (Crowther, Smythe & Spence, 2014). Midwives and obstetricians' actions can influence the mood that mothers experience during the birth. The mood at birth can be safeguarded by certain factors such as allowing minimal people in the room, dimmed lights and limited interventions. On the other hand, the mood can be disrupted by a midwife's anxiety or the presence of an unfamiliar obstetrician who has no relationship with the mother but who needs to step in during emergencies that require interventions (Crowther, Smythe & Spence, 2014:24). A sudden change during the birth also influences the mood at the birth. The sudden change can be positive, for example the joy experienced when a baby is born after a delay during the birth, or negative, for example when the sudden change is caused by an emergency that requires immediate action and a hustle of midwives and obstetricians around the mother (Crowther, Smythe & Spence, 2014).

The accounts in which the participants expressed that they felt unimportant highlight that they felt a disturbance of the mood during the births. This relates to section 6.3.2 - unsettledness - but also to the participants' impression that they were not important, as well as their attending midwives' absence of 'attunement' to the birth. The participants described

the moods during the birth as stressful and anxious, and only positive and joyous once the babies were born.

#### 6.3.3.2.1.2 Felt disrespected

The need to be treated with respect emerged as a strong theme from the participants' narratives. This need was directly related to the nursing care they had received during labour and was not specifically related to their age during the pregnancy. Some of the participants reported how nurses shouted at them and spoke to them impatiently, while others drew pictures of themselves crying because of the way they were treated.

Adolescents mentioned respectful nursing care and being assisted with pain relief during labour as supportive behaviour that they perceived as helpful (Sauls, 2010). A woman, irrespective of her age, is at her most vulnerable during labour and childbirth. She is in pain and she is scared; to mistreat someone in this vulnerable position constitutes patient abuse and abuse of power, since she is defenceless (McMahon et al., 2014). She depends on the nurses and places her and her baby's lives in their hands, trusting that they will help her through the process since she herself does not know what to do to survive.

The dehumanising treatment that the participants in my study experienced was also reported by participants in other studies and countries (Warren et al., 2013). The prevalence of abuse in maternity health care settings is of great concern to the WHO (World Health Organisation, 2015e). Actual action and specific programmes are needed in order to address this health care issue and to ensure improved maternity care (WHO, 2015e).

In view of Stacey's narrative, it is difficult to imagine how a person in a caring profession could expect a mother, who had been through labour and who had given birth only a few hours ago, to bend down on her knees and clean a hospital floor with her own facecloth. This act seems vindictive, humiliating, inhumane and much like an attempt to exert power by punishing the adolescent mother for something that she could not be blamed for. Kruger and Schoombee (2010) reported similar abuse when they investigated the prevalence of abuse in SA maternity settings. Patients' narratives described them having to give birth on their own while the midwives ignored them and were verbally abusive (Kruger & Schoombee, 2010).

I bracketed my own pre-understandings of the abusive treatment that patients suffered when I witnessed the mistreatment of patients in my workplace. Following is an extract from my reflective journal in this regard:

#### Reflective Journal: 13 May 2014

*When we entered the room the girl was screaming and clinging onto her mother who was bent over the bed. Her legs were flailing in all directions. I heard her mother continuously talking to her and trying to calm her down. I took note of her name on the file and started calling her name over and over until she looked at me. I told her that the doctor and I were there to help her and we need her to cooperate with us. It took a while and a lot of screaming and kicking from her before she started listening to me but in the end she started calming down and followed my instructions to breathe slowly and deeply. With contractions she pushed.*

*While I was cleaning up the patient after she gave birth I have noticed bruises on her legs, upper and inner thighs specifically. She seemed so traumatised that I didn't want to make anything worse by asking uncomfortable questions so I left her to sleep once she also allowed me to deliver the placenta and clean up everything.*

*Two days later I found her in the postnatal high care ward. Her mother was with her again. I closed the curtains, sat down on the bed and asked them what had happened that she had these bruises. The mother and the girl both told me that the sister at the hospital to which she was initially admitted had slapped her because she was uncooperative when they wanted to insert a urinary catheter before she had to be transferred to our hospital. It was two days later and the bruises were still clearly visible, purple-reddish scars on her thighs.*

*I felt very upset by her story and so angry towards the person who did this to her. She was a young and vulnerable girl and it was obvious that she was scared during the birth, clinging to her mother while she went through childbirth. How can anyone in a caring position do this to a young and scared girl? Surely you must be in the wrong profession then if you do not have the compassion or empathy for your patients.*

#### 6.3.3.2.1.3 Felt ignored

The participants recounted how they were not helped immediately when they arrived at the hospital. They recounted only being attended to after a while, not knowing what was going on and why they were not helped. The participants experienced that the nursing staff were indifferent with regard to their pain and labour progress, and felt ignored by them.

These feelings of being ignored and being left alone concur with Chadwick et al.'s (2014) findings. Chadwick et al. (2014) reported the neglect and abandonment of patients in certain South African public maternity settings as factors associated with negative birth experiences.

Some of the participants in my study knew that they were entitled to pain relief. However, when asking for help and information they were ignored. This behaviour violated two of their basic rights as patients, according to the

National Patient's Rights Charter, namely: i) continuity of care, stating that a patient is not to be abandoned by a health care professional who is responsible for the patient's care without appropriate referral or hand-over to another health care professional, and ii) informed consent for denoting that every patient has a right to detailed and correct information regarding their illness, procedures and treatment thereof as well as the associated risks and costs (Health Professions Council of South Africa, 2008).

#### 6.3.3.2.1.4 Felt victimised

The participants in this study reported the fear of being victimised because of their age, as well as the inhumane treatment they received during childbirth. From the participants' accounts about their birth experiences, whether these were positive or negative, it is evident that their ages were something of which they were acutely aware and sometimes ashamed, throughout the process. The nursing behaviour, as narrated by the participants, reflected the victimisation of the participants. The participants assumed that they were treated badly because of their young ages. Contrary to the adult mothers in the ward, even the participants who had positive experiences were constantly aware of their ages and felt embarrassed by it.

Limited research was found into victimisation of or discrimination against adolescents during childbirth. Breheny and Stevens (2007) reported on health professionals' views of adolescents and motherhood. They found that health professionals tend to stigmatise adolescents and become judgmental towards them. Although Jewkes, Abrahams and Mvo (1998) did not focus on adolescents specifically when they explored why nurses abuse patients, they reported accounts of discriminatory behaviour towards adolescents as witnessed by other patients and narrated during conversations. Some of their participants reported the nurses who made disrespectful and snide



comments towards adolescents, humiliating them in front of the other patients (Jewkes, Abrahams & Mvo, 1998).

d'Oliveira, Diniz & Schraiber (2002) reported on the prevalence of violence against women in maternity health facilities. They found that some groups of people might be singled out and receive punishing treatment for not adhering to society's moral codes, such as adolescents who are sexually active (d'Oliveira, Diniz & Schraiber, 2002). The findings of my study correspond with those of d'Oliveira et al. (2002) as the adolescents reported that they were treated like children while other patients were treated with more respect.

Peterson et al. (2012) explored adolescent experiences of judgmental nursing care during the postpartum period in hospitals and found they were treated differently to the other patients. The authors interviewed nurses who looked after adolescents during childbirth and asked them to rate each other with regard to adolescent care. The nurses who scored their colleagues lower were questioned about the reasons for doing so, and they named the judgmental attitude of some nurses towards adolescents as one reason. They believed that such behaviour stigmatises them, based on their own beliefs of what was right and wrong (Peterson et al., 2012). In my study, none of the participants were aware of the abusive nurses and midwives being sanctioned in any way by their colleagues.

Over the years, working as a midwife in a labour ward has led to my witnessing many adolescent births. Undertaking this research was in part based on the question whether some of these young mothers were singled out and treated badly because of their ages and, if so, how had they experienced this treatment?

*I could not begin to imagine what these young mothers experienced during child birth. Sometimes they were scolded during childbirth; some of them were even physically assaulted by being struck on the inside of their thighs to keep their legs apart. I have heard midwives threatening to perform episiotomies without local anaesthetics. In my mind, these experiences surely affected them for a long time after having their babies? I was also left wondering if these young mothers ever resented their babies for causing them so much pain and abuse during childbirth? In my experiences with adolescent mothers I have observed mostly negative and judgmental approaches of midwives towards adolescents. They were scolded for being "bad" and then, during labour and childbirth, lectured about what the Bible says and what kind of mothers they will be if they cannot even look after their own children ...*

In order to monitor if women are being treated respectfully and with dignity, an evaluation or assessment protocol should ideally be put in place to provide women with the opportunity to give feedback about the quality of the care they have received. Only a few studies were found that described and implemented quality care assessment tools for maternity care. These tools include (i) checklists that patients completed in relation to the quality of care and a questionnaire to assess their level of satisfaction with the care they received (Simbar et al., 2009), (ii) a comprehensive questionnaire that a patient completed by agreeing or disagreeing with statements relating to the quality of the nursing care and her experience thereof (Bojö et al., 2004), and (iii) an optimality index assessment questionnaire that a patient completed related to optimal care with yes or no answer options (Murphy & Fullerton, 2001).

#### 6.3.3.2.2 Encouragement and kindness

Labour support is not reserved just for the labour period before the birth occurs but it also refers to the guidance of a woman through the event of the actual birth. Encouraging a woman on pushing techniques if she is unsure is part of a midwife's supportive behaviour (Adams & Bianchi, 2008).

Aside from nurses' general scope of practice to care for their patients, nursing care theories exist and are developed to support and enhance nursing care (Leininger & McFarland, 2006; Benner & Wrubel, 1989; Watson, 1985; Benner, 1984). The participants who felt cared for reported more positive birth experiences during the conversations. According to Nunes et al. (2014), one-on-one and respectful nursing care of a woman in labour positively influences a woman's birth experience. According to the NICE evidence-based guidelines, creating a respectful environment for every woman in labour is encouraged, as women are seen as individual human beings with individual physical and emotional needs who need to be cared for by compassionate health professionals (Nunes et al., 2014).

Caring and nursing go hand in hand and the act of caring for a patient, regardless of the diagnosis, is the core of the nursing profession. Watson identified and associated ten factors with caring in the nursing profession, which she called 'carative' factors and furthermore created a guideline for nurses as presented below (Watson, 2007:131-132):

1. 'Practicing loving-kindness & equanimity for self and other
2. Being authentically present to enable, sustain, and honour the deep belief system and subjective world of the self or another other person.
3. Cultivating of one's own spiritual practices; deepening self-awareness and going beyond the ego self.

4. Developing and sustaining a helping-trusting, authentic caring relationship
5. Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for
6. Creatively using presence of self and all ways of knowing of being or doing as part of the caring process; engaging in artistry of caring-healing practices
7. Engaging in genuine teaching-learning experiences that attend to whole person, their meaning; attempting to stay within another's frame of reference
8. Creating a healing environment at all levels (physical, nonphysical, subtle environment of energy and consciousness) whereby wholeness, beauty, comfort, dignity and peace are potentiated
9. Assisting with basic needs, with an intentional, caring consciousness of touching and working with embodied spirit of individual, honouring unity of being; allowing for spiritual emergence
10. Opening and attending to spiritual-mysterious, unknown existential dimensions of life-death, attending to soul care for self and one-being-cared for.'

Watson's 'carative' factors define her understanding of nursing care; however, in the realms of this study, these were linked to both the nursing staff and the participants' mothers. Even though the participants described one or two of Watson's carative factors, they experienced seemingly insignificant encounters of nursing treatment as caring, friendly and helpful. For instance, in relation to 'carative' factor seven, one participant remembered that being asked how she was feeling after giving birth and she

interpreted that this meant that the midwife cared about her. Another participant perceived a nurse rubbing her back during labour as helpful and friendly – relating to ‘carative’ factors four and nine.

The presence and support of the participants’ mothers, on the other hand, represented and fulfilled Watson’s ‘carative’ factors that the nurses and midwives lacked. The participants viewed a midwife’s small, friendly act as caring, but the support of the participants’ mothers during childbirth seemed to be more true to Watson’s ‘carative’ factors than the nursing actions. The participants’ mothers selflessly gave up everything to be with their daughters. They were available to care for their every need during childbirth. The mothers assisted their daughters emotionally – *“She’s my best friend”*; physically – *“She rubbed my back”* and spiritually – *“She told me sweet words and they just made me feel better”*.

Crowther, Smythe and Spence (2015) researched the spiritual concept of ‘being’ during childbirth. They explored the lived experiences of mothers and their birth companions, midwives and obstetricians at the moment of birth. They described the moment of birth as ‘kairos time’ and defined this term as ‘an indeterminate moment in which something special happens’ (Crowther, Smythe and Spence, 2015:453). The participants in their study described ‘kairos time’ in various terms such as powerful, mysterious, miraculous, a new beginning, a spiritual moment and a sacrament. ‘Kairos time’ therefore involves the spiritual component at the moment of birth; it is also used in the absence of the precise words to define the moment of birth (Crowther, Smythe and Spence, 2015). Watson’s spiritual dimensions, as described in factor 10, closely relate to the ‘kairos time’ and the participants’ spiritual experiences, which I observed rather than heard during the conversations. Although the adolescents spoke of joy, excitement and relief after the births, I observed a sense of wonder in their facial expressions and

interaction with their babies, as if they were still overcome by emotions about the births but did not have the words to describe their experiences.

Caring for mothers during childbirth asks for an encompassing approach of empathy and comfort. It also asks for a healing environment when applying Watson's theory of caring in nursing. Caring for a woman's basic needs, her emotional well-being and respecting her individuality, all form part of a holistic approach to caring; an approach that not many of the participants experienced.

When looking at the participants' experiences through the lenses of holistic care, as described by Watson, it becomes clear that the emotional and spiritual well-being of the adolescent mothers were not addressed during childbirth. From the perspectives of other nursing theorists, the lack of nursing as a caring profession was evident. Benner (1984) also approached caring from a holistic perspective and emphasised how important holistic caring was to the physical and emotional healing process of patients. In addition to this, Benner (1984) theorised that a practitioner who is engaged and actively participates in his/her clinical environment and patient-practitioner relationships, is the mark of an expert practitioner in his/her field. In light of this theory, my participants' accounts of abuse and neglect – with the exception of two participants – highlighted a lack of this critical factor for expert maternity care and practices. Benner and Wrubel (1989) emphasised expert clinical nursing practice as the core and most important aspect of caring when curing someone.

Leininger shifted her focus towards cultural aspects and care for patients in a culturally sensitive manner (Leininger & McFarland, 2006). Leininger – a nurse theorist – developed the *Culture Care Theory of Diversity and Universality* that focuses on approaching another person when caring for him by

acknowledging his background and cultural influences it may have on him (Alligood, 2014: 417- 441). Culture Care Diversity talks about the differences in care beliefs and different values and patterns between different cultures and humans. Culture Care Universality talks about the similarities of care and values between cultures and humans (Alligood, 2014).

The relationship between a pregnant woman and her midwife or other caregiver can have a positive or negative impact on her birth experience. Rijnders (2008) and Chadwick (2014) found that women who had negative relationships with their caregivers – not providing adequate support, pain relief, information or respectful care – reported negative childbirth experiences afterwards. Elmir et al. (2010) found that negative relationships with health care professionals – dehumanising behaviour, lack of information, degrading treatment - resulted in women feeling out of control of their experiences, violated and traumatised.

Sapountzi-Krepia et al. (2011) explored women's experiences of pregnancy, childbirth and obstetric care in Greece. They reported the needs that the women expressed regarding pregnancy care in the health care system. Participants' reports from Sapountzi-Krepia et al.'s (2011) study highlighted the power of the midwife-patient relationship. Positive experiences of childbirth were all based on positive relationships with their caregivers. Assistance, guidance and labour support were mentioned as importance aspects of the patient-midwife relationship (Sapountzi-Krepia et al., 2011).

A midwife's personal touch, providing encouragement, information and personalised care were all factors that the women in Cipoletta and Balasso's (2011) study mentioned as creating positive birth experiences. When adolescents are concerned, the patient-midwife relationship is just as important. Adolescents want midwives to give them respectful nursing care

and labour support. Having a bond with a midwife creates trust and results in a positive experiences for the adolescents (Sauls, 2010; Low et al., 2003). Midwives who care for adolescents in labour 'are seen often as the deciding factor in whether a woman's experience of childbearing is positive or negative'; they can play a significant role in promoting healthy outcomes for both the mother and the baby (Sauls & Grassley, 2011:24).

#### **6.4 ADOLESCENT CHILDBIRTH VERSUS ADULT CHILDBIRTH**

Similarities between adult childbearing and adolescent childbearing were identified throughout the course of my research. Regardless of their ages, three characteristics of childbirth experiences could be attributed to both adults and adolescents. These are as follows:

- childbirth is painful, although the level of intensity experienced differs from woman to woman regardless of her age or parity (Jones et al., 2015; Sawyer et al., 2011; Zasloff, Schytt & Waldermström, 2007; Low et al., 2003),
- experiences of abusive treatment at the hands of health professionals were found among my participants and were previously reported in studies regarding adult women (Chadwick, Cooper & Harries, 2014; Jewkes, Abrahams & Mvo, 1998), and
- unpreparedness – emotional, physical, psychological, informational - for childbirth not only pertains to adolescents, as other researchers found that unpreparedness and a lack of knowledge of danger signs in pregnancy are also common among adults (Bintabara et al., 2015; Matinnia et al., 2015; Fenwick et al., 2009; August et al., 2015).

The differences that I determined in my study between middle adolescent childbearing and adult childbearing are set out below.



- Adolescents regard childbirth as a process for which they are physically and emotionally not equipped. Although studies reported that pregnant adult women expressed one fear of childbirth as feeling unable to cope with childbirth due to a lack of self-efficacy, limited literature was available on adolescents' experiences of self-efficacy during childbirth. However, my study highlighted not only a lack of self-efficacy among adolescents during childbirth, but also an additional physical concern associated with only adolescent pregnancies. The participants expressed the fear that their bodies are neither fully developed nor ready to meet the physical requirements of childbirth. This was a valid concern, since it was possible that they have not yet reached physical maturity – refer to section 6.3.1.2. Most of the participants felt that they were also emotionally ill-equipped for the demands of childbirth. One participant expressed that childbearing is not good for an adolescent as it is “*too hard*” for them to cope with.
- The reports of victimisation are new perspectives on the abusive treatment that women experienced in maternity care settings. No studies were identified that reported on abusive treatment in the form of victimisation of adolescent mothers. However, Jewkes et al. (1998) mentioned narratives by patients who witnessed some discrimination against adolescents in the text. The participants in my study, however, reported different and more offensive behaviour from the nursing staff in comparison with other patients. The adolescents felt that they were treated like children and as if they were not worthy of respectful care because they were young.
- One noteworthy finding of my study was the participants' need to specifically have their mothers beside them as birth companions. The babies' fathers were never mentioned except for one participant. Other studies about adolescents' childbirth experiences referred to the

importance of partner support (Sauls, 2010; Sauls, 2004). A few studies mentioned the mother or a female relative as birth companion (Anderson & Gill, 2014; Khresheh, 2010).

The support and care adolescents receive from the nurses and midwives during labour and childbirth can contribute positively to how they experience the birth; especially if the care was age-specific to their developmental phase (Grassley & Sauls, 2012).

## **6.5 DEVELOPMENTAL TASKS OF ADOLESCENCE AND THE EFFECT OF PREGNANCY**

Rubin (1984) identified four pregnancy developmental tasks of women. According to Drake (1990:521), these four pregnancy developmental tasks have an impact on pregnant middle adolescents in the following ways (Drake, 1996; Rubin, 1984):

- while seeking safe passage for the baby and herself through pregnancy and childbirth, an adolescent may still not be self-assertive to voice concerns; late booking of the pregnancy is also common
- accepting the pregnancy – it is possible that adolescents become pregnant in an attempt to establish a more mature status in the community;
- the adolescent needs to accept the reality of the unborn fetus and may be willing to prioritise the needs of the fetus above her own. This behaviour is influenced by the fact that she is now developing her feminine identity by means of the pregnancy and is starting to comprehend the implication of her role as a mother; and
- the adolescent needs to accept the reality of becoming a parent, but depends on her parents for assistance if she wants to finish her

education. However, she may start taking on some parenting responsibilities of her own.

The impact of pregnancy (Drake, 1996:520) on the developmental tasks of adolescence (Mercer, 1990) is presented in table 3 with Erikson's fifth stage of the life cycle - identity versus role confusion - and Muuss' theories of adolescence (Muuss, 1996). These adolescent theories and the impact of pregnancy on middle adolescence are compared to the findings of the present study.

**Table 3: The impact of pregnancy on the developmental tasks of middle adolescents.**

Developmental tasks of adolescents Mercer (1990)	MUUSS(1996) and ERIKSON (1968) <i>Identity versus Identity confusion</i>	Adolescents' developmental tasks (Mercer , 1990) and the impact of pregnancy (DRAKE , 1996:520) <i>Impact of pregnancy on developmental tasks of Middle Adolescents</i>	MINNAAR  <i>Examples from the present study</i>
<b>Achievement of a stable identity</b>	Establishing a meaningful self-concept (Muuss, 1996). Struggling with the question of "Who am I?" and "What do I want to be?" (Erikson, 1968).	Developing a sense of self and what they want and how they want to conduct themselves. Possibly fell pregnant to confirm feminine identity.	Stacey's account of humiliating treatment highlighted her desire to be seen as a respected and responsible individual: "I wouldn't want her to pick it up but I was thinking if the people come in and the blood's lying there, what didn't they think of me?"
<b>Body image</b>	Reaches genital maturity and sexual awareness during adolescent phase (Erikson, 1968). In fact establishing a new body image to the one they had during childhood (Muuss, 1996)	The body reaches maturity and adolescents often react negatively towards the physical changes of pregnancy.	Unathi's negative perception of her body during pregnancy: "I'm just a fatty boom-boom with a big tummy."
<b>Sexuality</b>	Establishing meaningful commitment such as sexual identity (Erikson, 1968). They do not develop sexual needs as such but rather attempt to project their own diffused and undifferentiated egos through the eyes of a lover (Muuss, 1996). Different experiences of love relationships aids in developing their own identities (Muuss, 1996).	Possibly in relationship with father of the baby but lacking depth and closeness. Possibly desired pregnancy to reinforce relationship with father of the baby.	It was evident that there was a lack of closeness and depth with their sexual partners or ex-partners as the fathers of the babies were not mentioned. Only Mavis referred to her boyfriend: "Your mommy and daddy ... or your boyfriend ... should be there then you will feel all right, otherwise you will feel lonely."
<b>Personal value system</b>	This is where adolescents establish a personal philosophy of life and forms a belief system for themselves from where they can evaluate occurrences in their lives (Erikson, 1968). This frame of reference ultimately influences their personal value system and how they make choices and it guides their behaviour (Muuss, 1996).	Attempts to maintain good relationships to acquire approval from others. Listens and behaves according to suggestions for antenatal care to avoid reprimands from parents.	The participants unanimously felt that they needed to obey the instructions from midwives during childbirth. "I would tell them to just listen to the sister." Unathi. According to Aquila's frame of reference regarding equality of maternity patients: "We are all the same ... you can't treat others so bad and others ... we are all the same."
<b>Choosing a career</b>	Adolescents develop a vocational identity during this phase which may create anxiety due to an inability to settle on a career (Erikson, 1968). Middle adolescents often have idealised and unrealistic ideas of vocational roles (Muuss, 1996).	Usually in grades 10 to 12. If school performance is poor and there is lack of encouragement, motherhood may be the prime role.	The future plans and career choices of the participants did not form part of the conversations however, was mentioned by Cindy: "I am still young and I want to go back to school and I want to finish school."
<b>Establishing independency from parents</b>	Dependency on parents shifts to dependency on peers and social feedback (Erikson, 1968). There is little identification with parents and is a rather rebellious phase. Adolescents want to separate their own identities from their parents and family (Muuss, 1996).	There is still dependency on parents or other adults and adolescent have to share their own parenting responsibilities with other adults.	Independency from their parents was not yet established: (Farrah) "Well ... the bond with me and my mommy is ... we're like best friends...if she's there - she'll guide me in the right direction." Mavis expressed her dependency on her mother: "My experience was okay because my mom was with me."

Adapted from Erikson, (1968), Mercer (1990) Muuss (1996).

Based on the findings of my study, the participants had not yet achieved their developmental tasks at the time of childbirth. It is evident from the conversations that the participants were caught in an identity crisis, and even a complete loss of identity, not at all knowing who they wanted to be. Certain behaviour highlighted their attempts to establish their identities, like Stacey who did not want to feel ashamed in front of her family, and Farrah who did not want to scream like the other girls but rather prayed during labour. The participants' body images were expressed in negative terms; there was a lack of sexual closeness and depth with their partners (who were not involved in the birth process at all); all the participants were still dependent on their parents. One aspect that affected the study operationally was the participants' lack of autonomy in not being able to schedule or attend conversations with me, as well as their lack of resources to achieve this.

Overall it appears as if childbirth might have delayed the following developmental tasks of the participants: i) establishing a positive body image - feeling fat and embarrassed about their bodies; ii) establishing a close sexual relationship with their partners - the absence of the babies' fathers during childbirth demonstrated a lack of closeness with the partner; iii) choosing a career - uncertain if they will be able to finish school; and iv) establishing independence from their parents - financially they were still dependent. In terms of establishing an identity and a personal value system, childbirth enhanced their developmental tasks, as they now had an established identity as a mother and expressed ethical values about the way they should have been treated during childbirth.

## **6.6 STRENGTHS OF THE STUDY**

A strength of this research is the chosen age group of adolescents, 14 to 16 years. Adult mothers' childbearing experiences have been researched before,

while adolescent childbearing is under-researched. There is a dearth in South African literature on adolescents and how they experience childbirth, even though we have a high adolescent pregnancy rate. This study provides insight into and knowledge about childbirth from a younger mother's perspective, which is evidently different to that of an adult mother. As a result, necessary changes in their care may now be identified.

Bracketing my pre-understandings according to Husserlian phenomenology added to the rigour and trustworthiness of the study and is therefore regarded as a strength. Before and during the fieldwork I identified my own thoughts and feelings about the research. I kept a journal throughout the study in order to bracket these. In addition to the journal I frequently met with my supervisors to discuss my feelings about the information I was gathering in order to identify subjective feelings that I needed to bracket. After every conversation with a participant I went back to the audiotapes to listen to my own voice and to identify any bias or leading questions before I conducted the next conversation.

Methodologically, even though I was a novice researcher, being the instrument to gather information for my research was advantageous to my study. Speaking two of Cape Town's most commonly used languages made it possible for me to reach more potential participants. Being a young woman myself made it easier for the participants to relate to me and to feel comfortable in my presence than it might have been with an older person who they might have seen as an authoritarian figure. During the initial meeting I presented my topic to all the participants. Knowing my concern for their well-being during childbirth, they could feel reassured that I would not be prejudiced or judgmental towards them.

My study provided an in-depth view of the treatment to which adolescents are subjected during childbirth. In addition, my study highlights certain harmful as well as helpful ethical and professional practices that health professionals exercise towards adolescents. Before I started with fieldwork, I bracketed my own pre-understandings of the experiences I expected to hear from the adolescents. The reality, however, proved to be different and worse in some areas and better in others. I expected mostly negative birth experiences, since I know from my own experience in a labour ward how adolescents are sometimes treated. However, I was surprised to learn of positive memories based on a nurse's smallest gesture of care. This made me realise that adolescent-friendly care can be achieved just by providing friendly and non-judgmental care. Thus I ensured that both the negative and the positive memories were described during information unravelling.

My study provides evidence that confirms the prevalence of ongoing abusive care in South African maternity units. Along with the three South African studies and their accounts of dehumanising treatment at the hands of nursing staff, my study may serve as a foundation to determine factors that can improve respectful nursing care in the South African health system (Chadwick, 2014; Kruger, 2010; Jewkes, Abrahams & Mvo, 1998). Further research is required to explore this phenomenon. My recommendations are presented in chapter 7.

Another strength of my study is that most of the findings and themes identified during the conversations corresponded to other studies on adolescents' needs during labour, even though the contexts were vastly different (Sauls, 2010; Sauls, 2004). The needs that I identified in this research, as well as the results of Sauls' studies, can be addressed and put into action towards improving the mental and physical well-being of adolescent mothers and providing them with more positive birth experiences.

During the course of my research I uncovered a gap in the literature regarding information on adolescents' experiences of self-efficacy during childbirth. While adult women's self-efficacy during childbirth received attention in the research field, research into how adolescents experience and cope with childbirth based on their level of self-efficacy is lacking.

## **6.7 LIMITATIONS OF THE STUDY**

As a novice researcher, this was my first exposure to the research field and I encountered some obstacles along the way.

Although I have been working with adolescent mothers for years now, I still did not understand their psychological development and social circumstances well enough. After months in the field I had to change the initial timeline of my conversations with the participants from two weeks postpartum to within 72 hours after the birth, as they did not return for the conversations two weeks postpartum. On multiple occasions I waited in vain for the participants at the hospital, even though we agreed on a time and date for the conversations. I was unable to reach them thereafter. Furthermore, the rapport established after the birth was not enough to motivate the participants to return for the conversations in light of matters such as transport, financial limitations and no direct personal gain from the study.. In relation to this, these adolescents' lack of autonomy to decide to return for the conversations, for those who wanted to, was something I had not anticipated.

After receiving ethical approval for the protocol amendment (appendix G) to conduct the conversations soon after birth and then a two-week follow-up conversation, I encountered the non-return problem once again. Only three participants returned reluctantly for the follow-up conversations, and all



three conversations were short and to the point. The adolescents showed little interest in the feedback of the research that I presented to them. The reasons they offered – those who answered my calls – for not wanting to come or not being able to come were transport problems, no money to travel, no one to look after the baby and forgetting about the appointment. The change of time, however, did not yield any further information after two weeks – one participant returned for the initial conversation two weeks after giving birth. Initiating the first conversation within 72 hours of the birth proved to reveal richer information, since the participants were still living their experiences instead of reflecting back on them.

Prior to amending the timeframe for the conversations from two weeks to 72 hours after they gave birth, a few adolescents agreed to participate but did not return for the initial conversation. They most probably felt that they would not gain anything from the conversations and therefore did not consider it a priority to return. I did not bear this factor in mind. The option to visit them at their homes was not realistic due to concerns for my personal safety in doing so. Consequently I respected these potential participants' choices to not participate any further and excluded them from the study.

Although these potential participants' avoidance is seen as a limitation, it was also an insight that has possibly been overlooked in the past. This behaviour of the participants demonstrated the socio-economic and financial challenges that adolescents have to face after childbirth of which we are often not aware. In addition, this avoidance demonstrated their level of emotional maturity in that they chose to rather ignore an unwanted phone call and conversation instead of being autonomous and saying that they are no longer interested in participating in the study.

I anticipated the conversations would be longer than 40 minutes, but none of the participants conversed longer than 35 minutes. Seen as a limitation due to reduced time with the participants, this, however, did not affect the richness of the information. The participants needed probing and prompting questions to elaborate on their narratives, since their recounts were usually short and direct. The drawings that I used to initiate the conversations helped to keep the participants focused and to elaborate on their stories, which are seen as a strength to counteract the shorter conversations.

Lastly, I encountered an obstacle right after I obtained ethical approval to conduct the study. The first hospital did not yield any possible participants for several weeks. All the adolescent patients had high-risk pregnancies or other complications that excluded them from the study. The study was then extended to another hospital, from which four of the participants were recruited. Eventually I recruited two participants from the initial hospital.

## **6.8 CONCLUSION**

The conversations with the participants provided valuable insights into the world of a middle adolescent girl giving birth to her first baby, as well as the experiences and memories she takes home with her. The themes were formulated in the Husserlian framework and discussed in terms of existing literature on this phenomenon.

There is still a dearth of research concerning adolescents and their experiences during childbirth. Literature on this phenomenon is limited and the topic needs to be explored more extensively. It is, however, evident from the existing literature that adolescents experience childbirth differently from adult women. They therefore require adolescent-oriented labour and childbirth care. It is also evident that the health care professionals that are

required to attend to adolescent mothers during childbirth often display unprofessional and unethical behaviour that greatly influences the adolescents' childbirth experiences.

## **CHAPTER 7**

### **CONCLUSION**

#### **7.1 INTRODUCTION**

The concluding chapter summarises the research process of my study. The methodology, as well as the information gathering and unravelling processes, is briefly described. The identified themes and sub-themes are summarised in the context of Husserl's phenomenology.

Recommendations for nurses and midwives working with adolescent mothers during childbirth are presented in this chapter. Furthermore, this chapter presents recommendations for future research into this phenomenon, before finally concluding this research.

#### **7.2 OVERVIEW OF THE METHODOLOGY**

##### **7.2.1 Problem Statement**

In my everyday work experience as a midwife in a labour ward, I noticed differences between the adolescent mothers in labour and the adult mothers in labour. While supportive measures such as pain relief and birth companions were in place to assist mothers in labour, it appeared that the adolescent mothers needed additional support and assistance during birth. This state of affairs left me with the question of whether or not adolescent mothers' needs during childbirth differed from those of adult mothers and, ultimately, if their childbirth experiences differ from those of adults.

The literature on adolescent childbirth experiences and adolescents' supportive needs during childbirth is limited to a few studies (Mollborn & Jacobs, 2012; Sauls, 2010; Bender, 2008; Wahn, Nissen & Alhberg, 2005). I therefore undertook this study to explore the under-researched phenomenon of adolescents and their childbirth experiences. The research question was formulated as follows: "How do middle adolescent mothers in the Western Cape experience childbirth?"

### **7.2.2 Aim of this Study**

The aim of this research was to explore middle adolescents' experiences of childbirth. The first objective of this research was to identify the needs of adolescent mothers during childbirth.

The second objective was to offer recommendations regarding the nursing care of adolescents in labour.

### **7.2.3 Study Design**

A qualitative design was chosen as methodology for the purpose of this study, as well as the philosophy of Edmund Husserl was adopted. Husserl's phenomenology formed the underpinning of the study and guided the process of information gathering and information unravelling.

### **7.2.4 Study Setting and Sampling Methods**

The study was undertaken in South Africa, in the Cape Town Metropolitan area. Two referral hospitals in the public sector were chosen for participant invitation. Convenience sampling was used. Potential participants were invited to take part in the study provided that they met the inclusion criteria.

To be eligible for the study, potential participants needed to be girls between 14 and 16 years of age and must have had a normal vaginal birth that resulted in a live, full-term baby. The potential participants with unbooked or high-risk pregnancies, or obstetric and neonatal complications, were excluded from the study. Only English or Afrikaans speaking girls were invited to participate in the study.

### **7.2.5 Participant Invitation**

Ethical approval to conduct the study was obtained from the Human Research Ethics Committee of the University of Cape Town's Faculty of Health Sciences as well as from the Western Cape Provincial Government. Potential participants were approached within 72 hours after giving birth, in the hospitals' postnatal wards and invited to participate in the study. Since the potential participants were minors, informed consent was obtained from their parents/legal guardians and informed assent from the participants. Participation in the research was voluntary and the participants were informed of their right to withdraw from the research at any time without any negative consequences.

### **7.2.6 Information Gathering**

As the sole researcher of this study, I was the information gatherer during the field work. I implemented the Husserlian approach's eight steps in the process of gathering information (refer to section 4.2.2). I bracketed my pre-understandings of the phenomenon before commencing with the fieldwork. The conversations with the participants were scheduled for within 72 hours after birth. An initial semi-structured conversation was held within the same timeframe, with a follow-up conversation two to three weeks later.

During the conversations, the participants were asked to draw their childbirth experiences. The conversations were audio-taped and commenced by asking the participants to explain their drawings.

#### **7.2.7 Information Unravelling**

The Husserlian method requires the researcher to explore clusters of themes when unravelling the information and to attach meaning to the participants' statements. In order to stay true to the phenomenological process, I followed Colaizzi's seven-step unravelling method during the unravelling process (refer to section 4.3.4.1).

#### **7.2.8 Rigour of the Study**

The rigour of the study was ensured by addressing different aspects of trustworthiness throughout the research. Audio-taped recordings and field notes of the conversations represented referential adequacy. My supervisors provided peer review, and an independent coder was used during the information unravelling phase in order to assess if the evidence from the phenomenological conversations supported the identified clusters of themes. The participants did member checking during the follow-up conversations. I kept a reflective journal throughout the research in which I bracketed my thoughts and emotions regularly. This journal, together with the drawings, field notes and conversations on audiotape and verbatim transcriptions, served as an audit trail of the research process.

### **7.3 SUMMARY OF THE THEMES**

The concept of personhood was recognised during information unravelling of the participants' narratives. It emerged from the participants' revelations

of feeling “*useless*” and “*I felt like a person again.*” The preservation of personhood emerged as the over-arching theme of the findings. This theme was defined by a desire for respectful and dignified nursing care, free from harmful and abusive nursing practices. Three approaches in the health system supporting the preservation of personhood were identified and described as consumer, holistic and health service approaches. The Midwifery Model of Care which focuses on empowering women through childbirth, and the concept of *Ubuntu* referring to being human were described in relation to personhood (see sections 6.2.2-6.2.3).

Three of Husserl’s essential phenomenological concepts - *essence, intentionality and consciousness* and *life-world* - guided the framework during the identification of the three essential themes and clusters of sub-themes and categories.

### **7.3.1 Essential Theme one: Unpreparedness**

The *essence* of adolescents’ childbirth experiences was unpreparedness characterised by ignorance of childbirth, feelings of inadequate physical development and a lack of emotional preparedness for the birth.

### **7.3.2 Essential Theme two: Unsettled**

The adolescents’ *intentionality and consciousness* during childbirth was an unsettled state of mind. They feared being alone, they feared for the baby’s well-being and they feared mistreatment by the nursing staff. They used a submissive approach as a coping mechanism. They expressed the need to cope with their unsettled state of mind and wanted their mothers to be present as birth companions during childbirth. In addition they needed continuous encouragement and guidance during the birth process.



### **7.3.3 Essential Theme three: Overwhelming Experience**

The participants' *life-world* during childbirth was identified as an overwhelming experience divided into intrapersonal experiences – an overwhelming level of pain and emotions – and interpersonal experiences described by nurses' dehumanising behaviour and victimisation on the one hand, and other nurses' kindness and encouragement on the other.

### **7.3.4 Developmental Tasks of Middle Adolescents**

The impact of pregnancy on the developmental tasks of adolescents (see section 6.5) was compared to the findings of my study and it became evident that pregnancy delayed the developmental of the tasks of the participants in terms of establishing positive body images, sexual closeness with partners and independence from their parents as well as choosing a career. The impact of pregnancy on the developmental tasks of adolescents enhanced the establishing of an identity (as a mother) and personal value system (expressed what they felt was right or wrong during childbirth).

## **7.4 ADOLESCENT CHILDBIRTH VERSUS ADULT CHILDBIRTH**

In order to identify appropriate nursing care, the distinction between adolescent mothers and adult mothers' needs during labour requires clarity. The following shared experiences between adolescents and adult mothers were identified: i) childbirth is painful; ii) abusive treatment is experienced by women of all ages within healthcare facilities; and iii) unpreparedness for birth.

Three characteristics were identified as unique to middle adolescents and were not experienced by first-time adult mothers.

- They feel physically underdeveloped and emotionally unequipped for the demands of childbirth.
- They were victimised by the nursing staff because of their age.
- They specifically expressed the need to have their own mothers present as birth companions during labour, while the babies' fathers did not feature as support persons.

While there are many areas of similarity, there are specific aspects that require a more sensitised approach for middle adolescents during childbirth.

## **7.5 RECOMMENDATIONS FOR NURSES AND MIDWIVES CARING FOR ADOLESCENTS DURING CHILDBIRTH**

On the grounds of the themes and sub-themes identified during information unravelling of the phenomenological conversations, the following recommendations for practice were formulated for both nurses and midwives who care for middle adolescents in labour. Adolescent centred interventions are presented in sections 7.5.1 to 7.5.5 and thereafter midwife centred and health service centred interventions are presented in sections 7.5.6 to 7.5.8.

### **7.5.1 Addressing Ignorance**

Different factors bring about ignorance among adolescents of their pregnancies and the birth process. These factors include social challenges at home and a fear of abusive treatment at local clinics, as revealed by both my own and previous research (Montgomery, 2003).

If women have a realistic notion of normal childbirth on which to base their expectations, they may be better prepared, emotionally and physically, for the birth process. Some studies have reported how the media's often incorrect portrayals or representations of childbirth can influence individuals' perceptions and expectations regarding their own imminent births negatively (Morris & McInerney, 2010; Low et al., 2003).

A condensed approach to antenatal education for pregnant adolescents emerged as great need, since they tend to book their pregnancies only in the later stages, and do not regularly attend health clinics. Antenatal education may reduce adolescents' fears of being physically underdeveloped and emotionally not able to withstand childbirth and prepare them for the health-care environment. Accurate information about their bodies and development may positively influence their feelings of competency regarding the imminent birth process. In addition, antenatal education programmes at local clinics or alternative settings such as schools or adolescent support groups, may inform expectant adolescents about the danger signs to be aware of during pregnancy, the signs of labour, the length of labour and pushing during the second stage of labour. These educational strategies may assist pregnant adolescents in being better prepared for labour and birth (Acharya et al., 2015; Kabakyenga et al., 2011).

### **7.5.2 Addressing Fear**

The participants' experience of an unsettled mind-set was partly based on a heightened state of fear. Fear for the baby's well-being mainly stems from a state of ignorance about childbirth, which may be addressed by means of antenatal education strategies, as mentioned in section 7.5.1. The fear of being mistreated by the nursing staff, however, was mostly based on previous experiences at the antenatal clinics they attended where the

participants were humiliated in front of other patients. More fear and anxiety were created when the participants experienced victimisation from the nurses during labour (refer to Unathi and Farrah's explanations of their experiences on pages 101 and 105). It is my recommendation that pregnant adolescents' mothers or female relatives should accompany them during antenatal visits to a clinic. During childbirth, adolescent-friendly services should encourage a pregnant adolescent to bring an older female relative with her as a birth companion.

Firstly, the accompanying person acts as moral support and a possible barrier between the adolescent and the nursing staff of whom she may be fearful. Secondly, an accompanying person will also receive all the necessary information about pregnancy and the birth process, and would thus be in a position to assist the adolescent at home.

### **7.5.3 Continuous Support during Labour**

The fear of being alone and the participants' expressed need to have their mothers with them during childbirth have overlapping aspects. Recommendations are made to address these matters. From the phenomenological conversations it appeared as if mistreatment by the nursing staff was experienced more often by the participants who were alone during childbirth. This trend may possibly increase their fear of being alone; therefore continuous support for pregnant adolescents during childbirth should be encouraged. The participants reported better nursing care when their mothers were present, since they felt protected.

Hodnett et al. (2013) highlighted the importance of continuous support for women in labour in general and the study was not age-specific. However, my study's findings corroborate the importance of such support, and I

further recommend that the adolescent's mother should be the birth companion. It was evident from my study that the adolescents wanted their own mothers instead of their partners as support during childbirth. The focus of support was thus on the adolescents' mothers, based on their relationships with their daughters. The adolescents felt that their mothers knew them best and that they trusted them; therefore their mothers would be the best companions for them.

The presence of a birth companion was also found to reduce the need for analgesia during childbirth (Hodnett et al., 2013). The participants mentioned pain relief as an important need; consequently the presence of their mothers as birth companions will contribute to this aspect as well. The community can become involved by being trained as doulas to act as birth companions when a woman has no one else to accompany her (Hodnett et al., 2013). Therefore it is recommended that all adolescents should have their own mothers as birth companions during labour, irrespective of their partners' presence or absence. A partner's presence may be in addition thereto if the adolescent desires it. In the event of a mother not being available, continuous support by the adolescent's partner, a doula or other female relative is encouraged.

The Adolescent Support Model (ASM) was described by Sauls & Grassley (2011) and designed for adolescents during childbirth. The ASM describes four assumptions regarding the childbirth experiences of adolescents and how their experiences can be influenced more positively. The supportive measures described in this model may serve as be tested a tool in improving adolescents' support structures in South African maternity settings and enhance their childbirth experiences (see section 2.3.3).

#### **7.5.4 Submission versus Autonomy**

A sub-theme identified during my information unravelling was that the participants relinquished their personal control to the midwives' authority. Unique to adolescents was their perception that as young and ignorant first-time mothers they just had to listen to the midwives and did as they were told. The adolescents surrendered their control to the midwives and followed their instructions based on the belief that this was the only way in which they could safely give birth. This was in line with Drake's (1996) theory that middle adolescents tend to follow higher authorities' suggestions in order to maintain good relationships. Although it was evident that the participants were unprepared for the birth process and not knowledgeable about childbirth, they should be assisted to preserve their autonomy during childbirth and to have a voice of their own.

It is recommended that midwives who care for adolescent during childbirth practise shared decision-making. Shared-decision making in order to encourage autonomy applies to adolescent and adult women during childbirth. However, as the developmental tasks of middle adolescence requiring adolescents to establish an identity and personal value system are influenced by the impact of pregnancy (see section 6.5), adolescents may be less inclined to assert their autonomy than adult women. Shared-decision making encouraging autonomy may involve the adolescent making the following choices: i) the preferred position during labour; ii) the type of pain relief during labour; iii) her birth companion during labour; iii) the number of birth attendants during labour; iv) the position in which to labour and give birth; and v) continuity of care during the postpartum period immediately after they have given birth.

### **7.5.5 Pain Relief**

Based on the findings of previous studies, the need for pain relief does not only apply to adolescents in labour, but to all women (refer to discussion in section 6.3.3.1.1). It was, however, suggested that adolescents may find childbirth more challenging due to their lack of life experience and their subsequent lack of coping mechanisms (Zasloff, Schytt & Waldenström, 2007). My study's findings have highlighted the need for good pain assessment and the design of a suitable tool for this purpose (refer to section 7.6). Once the level of pain is established, the health care professional can provide the adolescent with a variety of pain relief options. The adolescent should be informed about her options during the antenatal period when she is in a calm state of mind, and not in the midst of contractions. However, if she is not aware that she has pain relief options, she should be informed about the different methods including the side-effects of these.

### **7.5.6 Additional Training for Midwives and Nurses**

I recommend additional training for midwives and nurses who work with adolescents that focuses on respectful, non-judgmental and holistic care for adolescents during childbirth. Programmes or in-service training may be designed and implemented in order to bring about an attitude adjustment among health care professionals towards adolescents during childbirth.

### **7.5.7 Monitoring the Quality of Care**

The adolescents' narratives of verbal abuse and victimisation draw attention to the need for midwifery care evaluation and feedback opportunities for adolescents after giving birth. Maternity settings may apply existing quality

assessment tools to create a basis of continuous evaluation of midwifery care and a possible encouraging environment to enhance performance.

Monitoring the quality of nursing care is often overlooked when promoting better and improved care. The focus is on implementing better and more comprehensive policies to improve the quality of care; however, it is my personal opinion that the monitoring and evaluation of the quality of care are undervalued and the quality of care arguably has not improved, based on three studies in the same setting over a 18 year period.

#### **7.5.8 Adolescent-oriented Care**

Adolescent-oriented care or adolescent-friendly care refers to policies and procedures that are put in place to address adolescents' specific needs based on age, gender, ethnicity and religion, with free or affordable services (World Health Organisation, 2002). Adolescent-oriented maternity care is under-researched. Existing studies have, however, indicated positive outcomes associated with adolescent-oriented maternity care such as reduced preterm deliveries, improved breastfeeding rates and improved maternal health post-birth (Peterson et al., 2012; Grassley, 2011; Quinlivan & Evans, 2004).

The health service facilities where participants in my study gave birth were not adolescent-oriented; the participants felt victimised rather than receiving age-sensitive and age-specific care. Interventions, such policies on adolescent-friendly care, for adolescent-friendly care by midwives as well as nurses working in maternity need implementation such as adolescent-friendly policies to ensure improved care and experiences for adolescents during childbirth.



## **7.6 RECOMMENDATIONS FOR FUTURE STUDIES ON ADOLESCENTS AND CHILDBIRTH**

Adolescents' childbirth experiences appear to be an under-researched phenomenon and the opportunities for future research are numerous. The methodology of my research may be applied to different contexts both abroad and locally, since South Africa represents adolescents from diverse cultures. My research can be extended to the childbirth experiences of foreign adolescents residing in South Africa, since recent incidents of xenophobia may affect the adolescents' experiences of childbirth in the public health or public health sector services in general.

The link between appropriate and informational media exposure and birth preparedness is an under-researched phenomenon that may offer positive outcomes for antenatal education (Asp et al., 2014). However, future research is still required on adolescents in individual communities' (for example different ethnicities, cultures and religions) preparedness for giving birth, as well as programmes to improve their preparedness (Acharya et al., 2015).

My research focused on adolescent mothers between 14 and 16 years of age; however, more research is needed across the spectrum of adolescence. Future studies may explore the childbirth experiences of adolescents of different ages.

There is a need to develop an age-sensitive pain assessment tool for adolescents in labour. A possible combination of a paediatric pain assessment tool and a labour assessment tool can be explored and tested for effectiveness among adolescents in labour in order to better manage their pain. Designing and implementing a pain assessment tool may lead to future research in adolescent-oriented childbirth care.

In light of the accounts of mistreatment from the participants from this study and other research studies guided by the WHO, existing assessment tools for the quality of midwifery care during childbirth may be implemented. The midwives and nurses' care may be evaluated and areas for improvement identified and addressed.

The concept of adolescent-friendly health care services may be extended to implementing adolescent-friendly antenatal clinics in order to encourage expectant adolescents to attend more frequently. I further recommend the establishment of adolescent-friendly maternity units to which adolescents are admitted and in which they are cared for during childbirth by nurses and midwives trained in adolescent-friendly maternity care and practices. Presently, adolescent maternity units are not a reality in hospitals; it still needs to be implemented and the effectiveness thereof tested. This may be the ideal environment for optimal adolescent-oriented care.

No training programmes with an adolescent-specific focus of care for midwives exist in South Africa. This again offers research opportunities; further research needs to be done into the development, implementation and evaluation of such programmes.

There is a dearth in research on postnatal reflection sessions and the value that such interventions have for adolescent mothers after childbirth. The impact of these interventions could be researched in terms of i) the emotional well-being of adolescent mothers after giving birth, ii) the mother-and-baby bonding, iii) the prevalence of postpartum depression among adolescent mothers, and iv) the total satisfaction of their childbirth experiences.

Nurses and midwives caring for adolescents during childbirth present a different perspective on the phenomenon of adolescent childbirth. Exploring

not only the adolescents' childbirth experiences, but also their attitudes, cultural beliefs and caring for their new-borns are research areas that warrant exploration from the perspectives of both adolescents and midwives.

My research has revealed similar findings to that of other studies about adolescent childbirth as well as new information about this phenomenon. Similarities with regard to adolescent childbirth included a high demand for pain relief, respectful nursing care and the need for a birth companion (Sauls, 2010; Sauls, 2004; Montgomery, 2003). Adolescents' lack of self-efficacy during childbirth and reports of victimisation were unique factors identified in my study.

## **7.7 CONCLUSION**

It is evident from the participants' phenomenological conversations that childbearing does not only pose a physical health risk but also an emotional one. Their experiences are shaped by their interactions with the health care professionals, their level of preparedness for giving birth and the support they receive to carry them through this challenging time. As middle adolescents, the participants in my study experienced a loss of identity and sense of self during a developmental phase when establishing their identity is a key challenge.

The adolescents in my study experienced a wide range of emotions during childbirth that varied between fear of the impending birth, painful contractions, anger and frustration towards nursing staff for ignoring or mistreating them, humiliation when being shouted at in front of other patients, and then excitement and happiness when their babies were born and relief that they had survived childbirth.

In the course of this research, I was immersed in the adolescents' childbirth experiences, and for a moment these young mothers trusted me enough to share their journeys of a life-changing event and what they had been through. When I started with this research I was concerned about the way they were treated in health care services during childbirth. However, this research has given me insight into their world as adolescent mothers on the cusp of motherhood and generated a variety of opportunities for further research in this area.

The adolescents are transitioning from childhood to motherhood when they come into our care. According to the Midwifery Model of Care (Rooks, 1999), the onus is on all health care professionals to ensure that these young mothers return home feeling valued as human beings, worthy of care and respect, confident as a new mother and empowered as a woman.

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#### **Jane's story – Saturday 28 June 2014**

*I assisted Jane with her son's birth just before midnight on that evening.*

*As she lay sobbing on her side, curled into a fetal position, her mother spoke softly to her while caressing her hair. I handed her the tiny bundle and she cradled him in her arms, unsure what to do with her new-born son. After he has been transferred to the neonatal ward, I gently delivered Jane's placenta and cleaned her up. It was then that I noticed severe bruises on her thighs. She still seemed so traumatised that I did not want to intrude, so I left her to rest.*

*Two days later I located her in the high-care ward where she was monitored. I closed the curtains, sat down on the bed and asked Jane and her mother what had caused those bruises. They told me that a nurse in the day hospital struck Jane on her legs when she became uncooperative during a procedure before she was transferred to our*

*facility. It was now two days later and the bruises were still clearly visible; purple-reddish scars on her thighs that Jane tried to hide away underneath her hospital gown.*

*I felt distraught. The night of the birth I saw utter fear in Jane's eyes, not naughtiness or stubbornness. That was when I realised the impact that poor or quality midwifery care can have on adolescents during childbirth.*

*Jane was more scared of me than she was of childbirth.*

*The moment she started trusting me, her contractions became more bearable, she cooperated with us and gave birth to her son.*

*I still remember the doctor asking me during the birth: "How do you do this job?!" and telling her "With a lot of patience and care!"*

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## Appendix A: Approval from the Human Research Ethics Committee

	<b>UNIVERSITY OF CAPE TOWN</b> <b>Faculty of Health Sciences</b> <b>Human Research Ethics Committee</b>	
		<b>Room E52-24 Old Main Building</b> <b>Groote Schuur Hospital</b> <b>Observatory 7925</b> <b>Telephone [021] 406 6338 • Facsimile [021] 406 6411</b> <b>Email: <a href="mailto:shuretta.thomas@uct.ac.za">shuretta.thomas@uct.ac.za</a></b> <b>Website: <a href="http://www.health.uct.ac.za/research/humanethics/forms">www.health.uct.ac.za/research/humanethics/forms</a></b>

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02 May 2014

**HREC REF: 256/2014**

**A/Prof S Clow**  
Health & Rehab  
Nursing & Midwifery  
OMB

Dear A/Prof Clow

**PROJECT TITLE: THE CHILDBIRTH EXPERIENCES OF ADOLESCENT MOTHERS IN WESTERN CAPE**

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year until the 30<sup>th</sup> May 2015**


Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.  
(Forms can be found on our website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms))

***We acknowledge that the following student, Elizabeth Minnaar will also be involved in this study.***

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC reference no in all your correspondence.

Yours sincerely

  
**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, FHS HUMAN ETHICS**  
Federal Wide Assurance Number: FWA00001637.  
Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

HREC 256/2014

## Appendix B: Permission from the Western Cape Government and Tygerberg Hospital



**Western Cape  
Government**

Health

**Tygerberg Hospital**

**REFERENCE: Research Projects**

**ENQUIRIES: Dr G Marinus**

**TELEPHONE: 021 938-4141**

**HREC REF: 256/2014**

**The childbirth experiences of adolescent mothers in Western Cape.**

Dear Ms Minnaar

### **PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL**

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at Tygerberg Hospital.

**Signed**


**DR D ERASMUS  
CHIEF EXECUTIVE OFFICER**

*Date: 9 September 2014*

Administration Building, Francie van Zijl Avenue, Parow, 7500  
tel: +27 21 938-6267 fax: +27 21 938-4890

Private Bag X3, Tygerberg, 7505  
[www.capegateway.gov.za](http://www.capegateway.gov.za)

## Appendix C: Permission from Mowbray Maternity Hospital



Elizabeth Minnaar <lizane.minnaar@gmail.com>

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**research at MMH**  
5 messages

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**Sue Fawcus** <Sue.Fawcus@westerncape.gov.za>  
To: "Lizane Minnaar (lizane.minnaar@gmail.com)" <lizane.minnaar@gmail.com>  
Cc: "Sheila Clow (sheila.clow@uct.ac.za)" <sheila.clow@uct.ac.za>, Karen Moore <Karen.Moore@westerncape.gov.za>

Tue, Oct 7, 2014 at 7:42 AM

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Dear Lizanne

Re: Research "The childbirth experiences of adolescent mothers in the Western Cape"

We have discussed your research proposal at MMH and permission is granted for you to recruit appropriate patients at Mowbray Maternity hospital.

In order to make logistical arrangements for conduct of the study you may contact our ADN, Mrs Moore (0216595544)

Best wishes

Sue Fawcus

**Professor Sue Fawcus (MBBS FRCOG)**

**Head of Obstetrics , Chair[person MMH research committee**

**Mowbray Maternity Hospital**

**Professor**

**Department: Obstetrics/Gynaecology**

**University Cape Town**

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## **Appendix D: Consent Information for Parent/Legal Guardian**

### **Who are the researchers in this study?**

I, Elizabeth Minnaar, am a midwife and currently a student at the University of Cape Town where I'm busy with research to get a Master's degree in Midwifery. I want to do research on teenage mothers between 14 and 16 years and find out how it was as a teenager giving normal birth.

### **Why is this study being done?**

As a midwife I have worked with many teenagers during childbirth. I hope to get new information from this study to see exactly what kind of support and care teenage mothers need when they give birth.

### **Why are you being asked to give consent?**

If you are the parent/legal guardian of a teenage girl between 14 and 16 years, who had a baby recently, I would like to get your permission to ask her to take part in this study. If she chooses not to, her decision will be respected even if you as the parent/legal guardian said it's fine.

### **Who can participate in this study?**

A teenage girl between 14 and 16 years of age who recently had a baby; who attended the antenatal clinic once or more, it was her first pregnancy and she has had a normal birth of a live, term (nine months) baby with no problems before or after the birth.

### **What will the study involve and how is my daughter's privacy protected?**

There will be an interview between myself and your daughter, which will last between 60 – 90 minutes; and a picture that I will ask her to draw. The interview will be recorded on audiotape only, (no camera) and your daughter's name will not be mentioned in the study. No procedures will be done during the interview. A follow-up audio-recorded interview will be

held after a few weeks, about 60 minutes long, to discuss the previous interview with your daughter and clarify that the researcher understood everything that was discussed in the first interview and clarify any misunderstandings or add information.

### **What happens to the information?**

The recorded interviews will be saved on a disc after they have been typed and kept in a safe when not being used. The pictures made by your daughter and other participants will be labelled by numbers and not names so that no one will know who took part in the study, and also kept in a safe. All of this will be destroyed after 3 years.

### **Where will the interviews be held?**

The venue for both interviews will be at the hospital. The sessions will be held in a private room. I will pay up to R30 to cover your daughter's travelling costs each time.

### **How long will the study take?**

Participation in the research will be the interview session with a follow up session later on. The study ends at the end of this year (2014). Your daughter will have access to the end results.

### **What risks or benefits does the study have for my daughter?**

Participation in the research will not necessarily benefit her directly. Indirectly she may feel that talking about everything helps to deal with it all. Her taking part in this research however, is of importance as future teenage mothers can be helped based on the information I get out of this study. There are no physical risks to your daughter. If she feels emotional after the interview, I will sit and talk with her until she feels better. I also have a number available if she wants to be referred to additional support groups.

### **What if my daughter doesn't want to be part of the study anymore?**

Participation in this study is voluntary. Your daughter has the right to withdraw from the study if she so wishes, at any point and time with no need for explanation. Her choice will have no implications for any care she might receive or require from the health service.

### **Is there anyone I can contact for more information?**

If you wish to contact anyone for further information regarding this study, please feel free to contact my Supervisor, Professor Sheila Clow, email [sheila.clow@uct.ac.za](mailto:sheila.clow@uct.ac.za) or Cell : 083 659 5266 or Professor Marc Blockman, Chair of the Faculty of Health Sciences Human Research Ethics Committee email : [marc.blockman@uct.ac.za](mailto:marc.blockman@uct.ac.za) or 021 406 6492.

For any further questions please contact me, Elizabeth Minnaar at: 082 6316 317

### **Consent from Parent/ Legal Guardian**

I \_\_\_\_\_ have read (or had read to me by \_\_\_\_\_) the Information Sheet. I understand what is required of my child/legal ward and I have had all my questions answered. I do not feel that my child/legal ward is forced to take part in this study and that she is doing so of her own free will. I know that she can withdraw at any time if she so wishes and that it will have no bad consequences for her.

I give the researcher my permission to audio-record the interviews with my daughter/legal ward. Yes ☐ No ☐

_____ Parent / legal guardian	_____ Date and place
_____ Researcher	_____ Date and place

## **Appendix E: Assent Information for Adolescents**

### **Who are the researchers in this study?**

I, Elizabeth Minnaar, am a midwife and currently a student at the University of Cape Town where I'm busy with research to get a Master's degree in Midwifery. I want to do research on teenage mothers between 14 and 16 years and find out how their birth experience was as a teenager giving normal birth.

### **Why is this study being done?**

As a midwife I have worked with many teenagers during childbirth. I've always wondered if teenage mothers have different needs and experiences during labour and childbirth than older mothers.

### **Why are you being asked to take part in this study?**

I hope to get new information from this study to see exactly what teenage mothers need when they give birth with regards to support and care.

### **Who can participate in this study?**

To take part in this study you need to be between 14 and 16 years old and have had a baby recently. If it was your first baby, it was a normal birth, there were no problems before or after the birth and you were nine months when the baby was born, you can take part in this study.

### **What is going to happen in this study and how will my privacy be respected?**

There will be an interview between me and you, which will last between 60 – 90 minutes; and a picture that I will ask you to draw. The interview will be recorded on audiotape only, (i.e. no camera) and your name will not be mentioned in the study. No procedures will be done during the interview. A follow-up audio-recorded interview will be held after a few weeks, about 60

minutes long, to discuss the previous interview with you and clarify that the I understood everything that was discussed in the first interview and clarify any misunderstandings or add information. Referral to additional teenage mothers support groups is available if you want their contact details.

### **How long will the study take?**

Participation in the research will be the interview session with a follow up session later on. The study ends at the end of this year (2014).

### **Where will the interviews be held and what happens to the information?**

The venue for both interviews will be at the hospital. The sessions will be held in a private room. The recorded interviews will be saved on a disc after they have been typed and kept in a safe when not being used. The pictures made by you and other teenage mothers will be labelled by numbers and not names so that no one will know who took part in the study, and also kept in a safe. All of this will be destroyed after 3 years. I will give you transport money of up to R30 every time.

### **What risks or benefits does the study have for me?**

Participation in the research will not necessarily benefit you directly. Indirectly you may feel that talking about everything helps to deal with it all. The importance of you taking part in this study is to help future teenage mothers during labour because what you say will tell me what kind of care and support teenage mothers need during labour. There are no physical risks to you. If you feel emotional after the interview, I will sit and talk with you until you feel better.

### **What if I don't want to be part of the study anymore?**

Participation in this study is voluntary based. You have the right to back out of the study if you want to, at any point and time with no need for



explanation. It's your own choice and nothing bad will happen to you if you back out and you will still get all the postnatal care you need.

**Is there anyone I can contact for more information?**

If you wish to ask anyone for further information about this study, please feel free to call my Supervisor, Professor Sheila Clow, [sheila.clow@uct.ac.za](mailto:sheila.clow@uct.ac.za) or Cell : 083 659 5266 or Professor Marc Blockman, Chair of the Faculty of Health Sciences Human Research Ethics Committee email : [marc.blockman@uct.ac.za](mailto:marc.blockman@uct.ac.za) or 021 406.

For any further questions please contact me, Elizabeth Minnaar at: 082 6316 317

**Assent from Adolescent**

I \_\_\_\_\_ have read (or had read to me by \_\_\_\_\_) the Information Sheet. I understand what is asked of me and I have had all my questions answered. I do not feel that I am forced to take part in this study and I am doing so of my own free will. I know that I can cancel or back out at any time if I want to and that it will have no bad consequences for me.

I give the researcher my permission to audio-record the interviews.

Yes ☐ No ☐

_____	_____
Parent / legal guardian	Date and place
_____	_____
Researcher	Date and place

## Appendix F: Protocol amendment

UNIVERSITY OF CAPE TOWN HUMAN RESEARCH ETHICS COMMITTEE		FACULTY OF HEALTH SCIENCES Human Research Ethics Committee	
16 JAN 2015			
Form FHS006: Protocol Amendment			
HREC office use only (FWA00001337; IRB00001938)			
<input checked="" type="checkbox"/> Approved	<input checked="" type="checkbox"/> Type of review: Expedited	<input type="checkbox"/> Full committee	
This serves as notification that all changes and documentation described below are approved.			
Signature Chairperson of the HREC	<b>Signed</b>	Date	17/1/2015
Note: All major amendments should include a P/Synopsis justifying the changes for the amendment (please see notice dated 23 April 2012)			
Principal Investigator to complete the following:			
1. Protocol Information			
Date (when submitting this form)	15 January 2015		
HREC REF Number	266/2014		
Protocol title	The Experiences of Childbirth of Adolescent Mothers in Western Cape		
Protocol number (if applicable)	N/A		
Principal Investigator	Elizabeth Minnaar		
Department / Office Internal Mail Address	Health and Rehabilitation Sciences lizane.minnaar@gmail.com		
1.1 Is this a major or a minor amendment? (see FHS006hlp) Major (tick box) Minor (tick box)	<input type="checkbox"/> Major	<input checked="" type="checkbox"/> Minor	
1.2 Does this protocol receive US Federal funding?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
1.3 If the amendment is a major amendment and receives US Federal Funding, does the amendment require full committee approval?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
2. List of Proposed Amendments with Revised Version Numbers and Dates			
Please itemise on the page below, all amendments with revised version numbers and dates, which need approval. This page will be detached, signed and returned to the PI as notification of approval. Please add extra pages if necessary.			
Version One April 2014			
2.6 Gathering of informational material			
2.6.1 Information Gathering			

## **Appendix F continued...**

### **Motivation to change time period of initiating first conversation**

Old Wording in normal text and **New Wording in Bold**

#### 2.6.1 Information Gathering

An in-depth phenomenological conversation will be held two weeks post-delivery, lasting 60 – 90 minutes.

**An in-depth phenomenological conversation will be held within 72 hours post-delivery, lasting 60 – 90 minutes.**

#### 2.6.2 Informational material gathering

The researcher will be engaging with the participant in the phenomenological conversation. During the phenomenological conversation, the researcher will use vocabulary that is familiar to the participants (Rubin & Rubin, 2005: 158).

The reflective drawing is required from the participant and will be initiated by the request: “Could you draw what happened in the labour room when you gave birth?” The phenomenological conversation is initiated after the drawing is completed by asking the participant: “Please tell me about your drawing.”

All the phenomenological conversations will be recorded on audio-tape to protect the identity of the participants and will be transcribed verbatim for information unravelling. During the phenomenological conversations the researcher will make field notes of observations made during the conversation and this will also be used as information.

Participants will be seen two weeks post-delivery to audio-record the phenomenological conversation. Motivation for the chosen time period is that mothers usually have established either breastfeeding or alternative

feeding, have had enough time for physical recovery from the birth and it is still early enough for the mothers to have a fresh memory and can recall the events and emotions.

**Conversations with the participants will be done at the hospital within 72 hours post-delivery to audio-record the phenomenological conversation. Motivation for the chosen time period is that the initial conversation can be done as soon as possible after birth when the memories are still fresh and the participants can remember more details and recall the feelings she experienced during childbirth .Rapport can also be established throughout the first interview which can motivate the participant to come back for the follow-up conversation.**

The location for the conversation sessions will be held at the selected hospital with permission from the hospital management. The participants' travelling costs will be reimbursed by the researcher (see budget considerations under no. 4). The researcher will use the session during which consent from parents/legal guardians and assent from participants is obtained, as an opportunity to create a rapport and establish a basic trust-relationship with the participant before the two week post natal conversation.

**The researcher will use the first conversation as an opportunity to create a rapport and establish a basic trust-relationship with the participant.**

The researcher will use techniques to encourage the participants to keep talking such as nodding of the head, making sounds indicating interest, asking probing questions on particular dimensions of importance to the study, reflection of what the researcher observes and utilising the drawing, asking the participants to elaborate on specific parts of the drawing and summarising (Burns & Grove, 2009: 510).

The researcher has completed training in group and individual interviews during her psychiatric nursing training and is qualified and confident to lead a therapeutic conversation and to facilitate interviews. Additionally, the

researcher has attended workshops on communication skills and interpersonal relationships, how to understand adolescents' behaviour and has attended seminars on adolescent approaches and listening skills when working with adolescents. The researcher has been assessed on many occasions during and after training and found to be competent to conduct interviews on all occasions.

## **Conclusion**

During the recruitment process I have spoken to many girls about their labours and births and my experience was the same as what was mentioned in the literature, they expressed more details about the birth and showed a lot of emotion shortly after which I felt lack during my interviews 2 weeks later. Additionally to the abovementioned literature to support my request, I have the following reasons:

- Doing the interview within 72 hours of birth or before the girl is discharged home, guarantees a first interview without the possibility of the participant not showing up
- Rapport can be established throughout the first interview which can motivate the participant to come back for the follow-up interview since we have already established a deeper relationship during the first interview
- All the referral hospitals have granted me permission to recruit as well as conduct interviews in the postnatal wards already
- The girls are by themselves for long periods during which the interviews can be done without interfering with nursing care. This possible concern was also addressed when the hospitals were approached- that nursing care will not be affected.

## Appendix G: Independent Coder's themes and sub-themes

Theme	Theme	Theme
She experiences an age related fear and panic <i>before</i> giving birth	She experiences various needs <i>while</i> giving birth	Her affective response shifts from fear to victory directly <i>after</i> giving birth
Sub theme	Sub theme	Sub theme
<p><b>Various perceptions lead to shame and panic:</b></p> <ul style="list-style-type: none"> <li>-expect rude treatment because she are so young</li> <li>-feeling not competent to handle the pain and to "get the baby out"</li> <li>-overwhelmed by the level of pain</li> </ul> <p><b>The good/ bad treatment of the midwife contributes to feelings of:</b></p> <ul style="list-style-type: none"> <li>-Fear</li> <li>-Dehumanised</li> <li>-Sadness</li> <li>-Gratitude</li> </ul> <p><i>"One nurse that was very cheeky...probably because I was underage" "Almost like: you're a kid man!"</i></p> <p><i>"I really thought that they're gonna treat me horrible ...reason being underage or so"</i></p> <p><i>"very sore...it's not a pain I can describe" "I was crying.... I didn't think I was gonna make it anymore" .."you're gonna die..."</i></p> <p><i>"The way they treated you if felt like you weren't gonna make it." "like a lost case" "You're not important, like you're not gonna make it" "it's almost like "okay it's your problem"</i></p> <p><i>"It made me feel like somebody that's useless because of the way she treated me"</i></p>	<p><b>Emotional needs:</b></p> <ul style="list-style-type: none"> <li>-to have a choice to be accompanied by her mother throughout the birth process (my mommy)</li> <li>-continued encouragement and rubbing of her back</li> </ul> <p><b>Information needs:</b></p> <ul style="list-style-type: none"> <li>-what is going to happen</li> <li>-what is expected of the girl</li> <li>-how to do the breathing</li> </ul> <p><b>Nursing care needs:</b></p> <ul style="list-style-type: none"> <li>-to be assisted and not to be left alone</li> <li>-to always be treated respectfully and with empathy in a calm way</li> <li>-clear instructions</li> <li>-to be allowed to ask for her mother to be at her side</li> </ul> <p><i>"you want someone to be there for you..." "it's only me..." "I asked them can my mommy come in..." "I prayed a lot and my mommy was rubbing my back"</i></p> <p><i>"My mommy..... She's there for me when I need her...it's not anybody that can sit with someone who's in labour."</i></p> <p><i>"My mother...we're like best friends" "I wanted my mommy by my side " She'll guide me in the right direction"</i></p> <p><i>"that nurse...you could see she knows how to handle her patients... that's nice... she helped me...good guide to me"</i></p> <p><i>"Breathing in and breath out, when the pain come..."</i></p>	<p><b>The sudden stop of pain brings great relief and profound joy</b></p> <p><i>"no pain at all any more... I thanked her like more than seven times... it's okay...it's done now, my pain is gone"</i></p>

Dr H.J.D Minnaar has independently analysed the following qualitative data of Elizabeth Minnaar of the University of Cape Town

I declare that I am an experienced independent coder of various qualitative studies done in the educational, nursing and chiropractic departments at the University of Johannesburg.

The research topic is not close to me as a coder, because I am not trained in midwifery and wasn't an adolescent when giving birth. I was not involved in selecting the population or conducting any discussions with the participants and was involved only in coding the transcribed interviews received. Adopting a "not-knowing" attitude contributes to the curiosity into the shared stories of the participants.

By focussing on the lived experience I move beyond preconceptions and apply bracketing by attending to the shared stories of the participants. By being aware of any bias at the start of the coding process, I consciously set aside my own ideas and beliefs to see their experience first-hand in a naive way. I do not have an experience of the phenomenon regarding the criteria of this study. The context of the study differs from the birth experience I myself have. Reflection before, during and after the coding process adds to the validity of the analysis process.

Thank you,

Dr HJD Minnaar